

PROGRESS NOTES

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Date/Time	Inmate's Name:	Kidy	D.O.B.: / /
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AL DEPARTMENT OF	? COF	RECTIONS	,		Name:_	DAV.	- Ricky
RADIOLOGY SERVICES REQU	_			$\mathcal{A}_{\mathcal{A}}$	State ID		173023 - 6-95
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Requesting Physician/PA/NP DAnsam		Date of moue	est te	Time of request	Routine	Priority	Transportation or special need
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Alslop

X-RAY TECHNOLOGIST'S SIGNATURE

DATE, TIME EXAM PERFORMED

X-RAY TECHNOLOGIST'S NAME (PRINT)

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Date/Time	Inmate's Name:	Davis, Ri	CKY	•	1130175
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PROGRESS NOTES

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1 (5/85)	Cc lete Both Sides Before Using Another Sho	



	PUC						***
	e area			Nursing Eval	liation T .		
		Facility: FC 5			uation 100l;		General Sick Call
		Patient Name:	D				- sustai Olck Call
	SF .		UAVI	>			
4	- 11	Inmate Number: 1	73023 Last		First	Z/ay	
	[Pate of Report:	1212		Date of B	irth. 7 30	25-11
		MM	DD YYYY	-	Time Seen:	MM DE	mr
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	Subjective:	Chief Complaint(s)	h	- 1	·		
		Onset.	TAX	- DAJ hur	IS For	//	
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9	Objective V	i i					
		ual Signs: (As Indicat	ted) T: 988	p. 7/	11	Da	Xt V. X
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Ass	essment (D.						
	☐ Referra	erral Status) Prelimii I <u>NOT REQUIRED</u>	nary Determin	ofice ()			
	DX Roform	MOT REQUIRED		auon(s):		Check He	re il additional notes on back
	→ Noterra	REQUIRED due to to	he following: (C	book du u			-
	5Ko	her: EVAL TOWN	ian 2 visits for the same	complaint)	oly)		
		- Principal		,			
	Community						
	appropriate care to	hould contact a physician a	and/or a nursing au				
Plan:	Check All That	hould contact a physician a be given. Apply: eturn if condition worsen		ervisor if you have a	ny concerns about th	Te status of the	
1	Instructions to r	Apply: eturn if condition worsens.				or the patient	or are unsure of the
-	is well as	patient demonstrates on	•				
Þ	Other: X-	eturn if condition worsens. Datient demonstrates an unite follow-up. OXYES OR RANDER	NO (If NO then so	e nature of their me	dical condition and	inches	
OTC Me	dications given	MY ET MANDIS	LA AL AT	hav: / / a	ppropriate follow-up	"ເຈດucuons regarding ⊇visits)	what they should do
Reform	of Committee	I NO D YES (If Yes	List):	WIRT CUP			
P.4	TI U NO XYE	A LT MANA'S NO YES (If Yes, Whom/Where): Urgent \(\text{I Emergent} \)	D- 2		,		
neterra	II Type: ÞXRoutine	☐ Urgent ☐ Emergen	of life	y _	, Data	for rot	
d		Urgent D Emergen	" (" emergent who	was contacted?):	Date	for referral: 1/5	1 4001
	Nurses Signature	<i>Y</i>				Time	****
	5		Name:	D. Beway L.			

EMERGENCY

INCORPORATED	IERGENCI
ADMISSION DATE TIME ORIGINATING F	ACILITY CONTESTING SICK CALL DEMERGENCY LOUTPATIENT
ALLERGIES PCW Wt. 161	CONDITION ON ADMISSION GOOD GAIR POOR SHOCK HEMORRHAGE COMA
VITAL SIGNS: TEMP Q 8 ORAL RESP	PULSE Q(0 B/P (40) 80 RECHECK IF SYSTOLIC / <100> 50
NATURE OF INJURY OR ILLNESS Society Chart Der TO	ABRASION /// CONTUSION # BURN XX FRACTURE Z LACERATION / SUTURES
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of face of Complaint	RIGHT OR LEFT
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t other injury noted.	ORDERS / MEDICATIONS / IV FLUIDS TIME BY
1- Bodychart per Doc	
2 No dy calcolod	
IAGNOSIS WOODED.	
ISTRUCTIONS TO PATIENT	
SGHARGE DATE TIME RELEASE / TRANSFER	The state of the s
DRSE'S SIGNATURE DATE PHYSICIANS SIGNATURE 730	☐ ☐ FAIR ☐ CRITICAL JRE
NMATE NAME (LAST, FIRST, MIDDLE)	DOC# DOB R/S FAC.
Davis Ricky	173073 1/30/75 W/m EQF
S-MD-70007 (White - Record Copy. Ye	Mow - Pharmany Carry



PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

Print Name: Ricky Wac	h Dave	D. C.	10 18	
ID#_173073	Date of 1	Date of Req Birth: <u>1/30/7</u> 3	uest: 12/30	5-13-11
Nature of problem or request:	2000 Bon	DEANO CO	Chienter C	00 kg 0e
# # 1000 PO TO	100 200	COMP	opaso Can	DEPORT
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ON 12/30/05 At 2:30 to 3500		2 Where I we	<u>23 ASSCUlfed</u> Davi ^e S 17307	By sgt BryAn
010 12/30/03 1/1 200 10 0000		They y	Signature	<u> </u>
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(S)ubjective:				
(O)bjective (V/S): T:	P:	R:	BP:	WT:

(A)ssessment:				
(11)35C3SHEIL.				
~				
(P)lan:				
Refer to: MD/PA Mental Healt	h Dental D	aily Treatment	Return to Clin	ic PRN
	CIRCLE (ONE		
If Emergency was PHS supe	MERGENCY (· Von () NI-		
Was MD/PA o	on call notified:	: Yes () No : Yes () No	• •	
		220 () 110	()	
	Cr	CNIATURE AND	TITLE	
WHITE: INMATES MEDICAL FIL		GNATURE AND	IIILE	
WHITE: INMATES MEDICAL FIL	JE.			

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)

AFFIDAVIT

STATE OF ALABAMA)
Berhour COUNTY)
I, Beth Long , hereby certify and affirm that I
I, Both Long, hereby certify and affirm that I am a Modical Records Clerk, at Foster ling Corrections;
that I am one of the custodians of medical records at this institution; that
the attached documents are true, exact, and correct photocopies of certain
medical records maintained here in the institution medical file of
one Ricky Wade Davis, AIS# 173013; and
that I am over the age of twenty-one years and am competent to testify to
the aforesaid documents and matters stated therein.
I further certify and affirm that said documents are maintained in the
usual and ordinary course of business at Arison Health Socvice;
and that said documents (and the entries therein) were made at, or
easonably near, the time that by, or from information transmitted by, a
person with knowledge of such acts, events, and transactions referred to
herein are said to have occurred.
This, I do hereby certify and affirm to on this the $\frac{15^{-6}}{10^{-6}}$ day of
February , 2006.
,
Beth Long
SWORN TO AND SUPSCIDED DEFORE ME THE THE
SWORN TO AND SUBSCRIBED BEFORE ME THIS THE
Day of February, 2005.
este esta 17 1000 Charles
otary Public
V Commission Evnisos

SPECIAL NEEDS COMMUNICATION FORM

Date: 1-14-06	
To: ADOC (Ewterling)	
From: PHS (Ewterling)	
Inmate Name: Oavis, Ricky ID#: 13073	
The following action is recommended for medical reasons:	
1. House in	
2. Medical Isolation	:
3. Work restrictions	
4. May have extrauntil	
5. Other) PPD Reading on Chon 1-16-06	
Comments:	
Date: 1-1486 MD Signature: V.SOV. Davbord Mclant Time: 1 p Rall Maria 173073	
XICTY 117301>	



RELEASE OF RESPONSIBILITY

Inmate's Name: Ricky Davis	
Date of Birth: 1-30-75 Social Security No.:	
late:	A.M. P.M.
This is to certify that I, Ricky Oavs	, currently in
stody at the Fuster line steet in Steet i	, am refusing to
cept the following treatment/recommendations: MD Appa	12-2-20
(Specify in D	etail)
I acknowledge that I have been fully informed of and understand the above treatment(solved in refusing them. I hereby release and agree to hold harmless the City/County/State, rsonnel, Prison Health Services, Inc. and all medical personnel from all responsibility and any ion/refusal and I personally assume all responsibility for my welfare.	etail) b)/recommendation(s) and the risks

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

EMERGENCY

RECOPURATED	a
ADMISSTION DATE TIME ORIGINATING FACILIT SIR DPDL DES	CAPE D SION OACE DEMENDENCY
10/24/05 3:25 PM SIR UPDL DES	□ OUTPATIENT
ALLERGIES CON	CONDITION ON ADMISSION GOOD FAIR POOR SHOCK HEMORRHAGE COMA
VITAL SIGNS: TEMP 979 RECTAL RESP	14 PULSE 90 B/P 114, 74 RECHECK IF SYSTOLIC / <100>50
NATURE OF INJURY OR ILLNESS	
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ISTRUCTIONS TO PATIENT	
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10/24/05 3:35 8	☐ AMBU'_ENCE ASATISFACTORY ☐ POOR ☐ FAIR ☐ CRITICAL
JRSES SIGNATURE DATE PHYSICIAN'S SIGNATURE	DATE CONSULTATION
NMATE NAME (LAST, FIRST, MIDDLE)	DOC# DOB R/S FAC
0 (1 4
Paris, Ricky	173073 1/30/75 W/M ECE
S-MD-70007 (White - Record Copy, Yellow	

EMERGENCY

INCORPORATED		CENCI	
ADMISSION DATE	ORIGINATING FACILITY SIR PDL ES	CAPEE D	SICK CALL DEMERGENCY
ALLERGIES ZANT dvessed	172# 16	CONDITION ON ADMISSION AGOOD □ FAIR □ POOR	
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TRUCTIONS TO PATIENT			
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SE SIGNATURE	DATE PHYSICIAN'S SANATURE	DATE CONSULTAT	☐ CRITICAL
MATE NAME (LAST, FIRST, MIDDLE)		DOC# DOB	R/S FAC
Jais hick	(White – Record Copy, Yellow -	173073 1-30 7	



RELEASE OF RESPONSIBILITY

Inmate's Name: KIC/S	of 7 141/2	e e 💉 e i i e 🧸 ee er englik ka en i e e englik ka en e i e e e e e e e e e e e e e e e e
Date of Birth:/ 36	Social Security No.:	87-24-7918
Date:	7/14/05 Time:	AM. ————————————————————————————————————
This is to certify that I,		. 1116
V	(Print Inmate's Name)	, currently in
stody at the		
	(Print Facility's Name)	, am refusing to
Cept the following track		·
cept the following treatment/reco		
	Specify in Detail	
	<u> </u>	*
	*	
1 acknowledge that I have to		
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United Filson Health Sondoon Inc	fully to form	commendation(s) and the risks tutory authority, all correctional fects which, may result from this
on/refusal and i personally assum	fully informed of and understand the above treatment(s)/re clease and agree to hold harmless the City/County/State, sta c. and all medical personnel from all responsibility and any ill ef the all responsibility for my welfare.	tutory authority, all correctional fects which, may result from this
en/refusal and I personally assum	fully informed of and understand the above treatment(s)/re clease and agree to hold harmless the City/County/State, state and all medical personnel from all responsibility and any ill ef	tutory authority, all correctional fects which, may result from this

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

EMERGENCY

INCORPORATED .	EVIERGENCI
ADMISSION DATE ORIGINATING SIR OPIGINATING SIR OPI	NG FACILITY SICK CALL EMERGENCY
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	CHILLY COX STEE
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PRUCTIONS TO PATIENT COLL	
CHARGE DATE RELEASE TRANS	FERRED TO DOC CONDITION ON DISCHARGE
DATE PHYSICIAN'S SIGN	TATURE DATE CONSULTATION
ALUA OVOIDS MATE NAME (LAST, FIRST, MIDDLE)	6/2/03-
Maria (Dor, Middle)	(DOC# DOB R/S FAC.
MUNS, KILLY	113013 VISUIS WIN East
MD-70007 (White – Record Copy,	Yellow Pharmacy Copy)



DEPARTMENT OF CORRECTIONS

KITCHEN CLEARANCE PHYSICAL ASSESMENT

	ANY OPEN SORES OR RASHE	S ON	YES	NO	
	HANDS, ARMS, FACE & NECK			\overline{X}	
	TB TEST CURRENT		<u>X</u>		
	DOES PT. SHOW ANY OBVIOU SIGNS OF ANY OTHER DISEAS	S SE		<u> </u>	
OTHER:					
			-		
THIS PATIENT HA	S BEEN INFORMED OF THE I	NEED FOR	THE FO	LLOWING:	
_ ,,,_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	OWASHING, NOT TO HANDLE WHEN NECESSARY AND TO N OF ANY ILL NESS	FOOD WHI OTIFY THE	ILE,SICK E DIETAI	K, SEEK MEI RY SERVICE	DICAL ES SHIFT
MEDICAL AUTHORI		_ DATE:	3/	15/25	
attest that the above PATIENT SIGNATUR	e statement is true to the best of m	y knowledge DATE:_		15/05	
EXPIRATION DATE:	alefinile				
	,				
INMATE NAME (LAST, FIRST	, MIDDLE)	DOC#	DOB	Race/Sex	FAC.
Uavi3 R	icky	TF3073	1/36/7	$\int \omega/m$	EAS
49-MD-70049 ARRES	.17 . 2			-	

PHS-MD-70042 (White - Medical File, Yellow - Kitchen Supervisor, Pink - Classification Administrator (Inmate))

PRO LDURE FOR ACCESS TO HEALTH CARE

Treatment for routine medical complaints and mental health complaints are processed through nurse screening seven days a week. Inmates must complete a sick-call screening form and turn this form into medical services for processing. You may obtain screening forms from any dorm cube or shift commander's office. you need to place the screening form in the locked box located at the dining hall. All health service requests are subject to \$3.00 co pay being deducted form your PMOD account, depending on the nature of your request. Forms for segregation inmates will be collected by nursing personnel at 4:00am medication rounds. Doctor's clinic is held Monday through Friday excluding holidays or an unexpected emergency.

Inmates on sick-call screening must report for screening or sign a refusal of treatment form declining care. Screening for population is held on 1st shift at approximately 7:00am. Screening for segregation is held during the morning pill call rounds. Sick-call screening is held Sunday through Friday.

Pill call times for this institution are as follows:

POPULATION 4:00am 9:00am 5:00pm

DIABETIC 3:00am 9:00am 3:00pm

SEGREGATION

4:00am 10:00am 5:00pm

Medical request on weekends and holidays are reviewed. Any request for medical attention that cannot wait until the next sick-call clinic will be processed at that time. All other request will be held until regular Sunday through Friday sick call. Medical emergencies, such as those involving intense pain, potential life-threatening situations, or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest Correctional Officer of an emergency, so prompt access to health care is provided.

You are required to sign up for Dental sick call using the same procedure as medical sick call. Population and Segregation Dental Screenings are held weekly on Mouday evenings at 1:00pm in the Health Care Unit. Follow-up care, if needed, is scheduled at this time. Emergency dental service is provided 24 hours a day with a dentist on call. Those not meeting scheduled appointments must sign a refusal of treatment form.

Your-medical care is important. This is a joint effort between you and the Health Care Staff. Prescribed medications are to be picked up at pill-call, appointments kept, and education in services attended.

Comfort medications, such as cold medicine, headache medicines etc. are available in the canteen.

We ask that medical complaints against the Health Care Unit try and be resolved face to face. If concerns cannot be resolved verbally, a written complaint may be filed. You may get this form in the Health Care Unit. You must complete this form listing specifically the reason for dissatisfaction, steps you have taken and the action requested to resolve the problem. Return this form to the Health Care Unit.

Innate Signature

ATS#

gight Height

Date

3/15/2

2140

FROM:

Sheriff Mac Holcomb

•	Marshall County
TO:	Department of Corrections Transfer Agent Supervisor FAX# (334) 240-3380 AND Medical Director (CMS) Kilby C.F. FAX# (334) 215-6681
Subject:	Authorization for Required Immediate Medical Care for State Inmate.
1. Conditio	Inmate: Ricky Wase Davis SS/AIS:
No m	on requiring immediate medical treatment outside jail: edication ordered at this time luled to have nodules removed (benign)
2. Medical	Professional who determined immediate care required: Phone
3. Date/Tir	me DOC contacted
4. Has det and tran	ermination been made that offender has been convicted script forwarded to DOC? YesNo
Submitted by	
a Aggles	Phone (256) 582-2034 Ext. 30

Officer's Signature

RECEIVING SCREENING FORM

INMATE'S NAME: DAVIS RICKY DATE: 1138 JOS TIM	E: 10:45 AM
DOB: 1/30/75 OFFICER: Darnel Magic INSTITUTION:	KILBY
RECEIVING OFFICER'S VISUAL OPINION	
	YES NO
Is the inmate conscious?	X —
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	— —
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	_ \(\)
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	_
Is the skin in poor condition or show signs of vermin or rashes?	
Does the inmate appear to be under the influence of alcohol, or drugs?	
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)	
Is the inmate making any verbal threats to staff or other inmates?	7
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	
Does the inmate have any obvious physical handicaps?	-6
FOR THE OFFICER	y .
Was the new inmate oriented on sick/dental call procedures?	
This inmate was a. Released for normal processing	
b. Referred to health care unit	
c. Immediately sent to the health care unit.	

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.

ALABAMA DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

MITAIN	TOLES
WIENTAL HEALTH 30/9	ODAY OF CO
Inmate Name: Danie Dicker	20 DAY SEGREGATION REVIEW
Date Review C	AIS#:/73073 Institution: ECF
Date Review Completed: 1006	Date Di
30 DAY PEVIEW	Date Placed in Segregation: 8-30-05
ALDOC Psychologist/P	LOODAY REVIEW RUMM MY 1.00
MENTAL STATUS TO	anducting Ravious Bullet Mitchell
MENTAL STATUS EXAMINATION Affect:	onducting Review: Brian Mitchell, Psychological Asst. II
Appropriate for a	Appearance:
Appropriate for Segregation Concentration:	
	Appropriate for Segregation
Appropriate for Segregation	Intellectual Functioning:
	Within Normal Time
Appropriate for Segregation	Memory:
Orientation:	Intact
Appropriate for Segregation	Speech:
Other:	
	Appropriate for Segregation
BEHAVIORAL	
Aggressive OBSERVATIONS	
Agitated Irrational	
Delusional Labile	<u>Passive</u>
Eye Contact Lethargic	(Rational)
Hallucinating Loose Associ	ciations Terrified/Crying
Hyperactivity Manipulativ	e Withdrawn
Paranoia COMMENTS:	Suicidal
	Other:
•	
•	

RECOMMENDATIONS:

X SEGREGATION PLACEMENT NOT IMPACTING INMATE'S MENTAL HEALTH SEGREGATION PLACEMENT IMPACTING INMATE'S MENTAL HEALTH REFERRED FOR PSYCHIATRIC EVALUATION

Inmate Name		
	AIS#	
	ALDOC Form	463-01

ALABAMA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES

MENTAL HEALT	H 30/90 DAY SEC	REGATION DEVIEW
STORY ALL HEAL [H 30/90 DAY SEG	RECATION DEVIEW

	ALDOC Form 463-01	
	AIS#	
Inmate Name	AIS #	
	*	
REFERRED FOR PSYCHIATRIC I	EVALUATION	
SEGREGATION PLACEMENT IM	ST IMPACTING INMATE'S MENTAL HEALTH FYALLING INMATE'S MENTAL HEALTH	
X SEGREGATION PLACEMENT NO	OT IMPACTING INMATE'S MENTAL HEALTH	
RECOMMENDATIONS:		
		•
•		
COMMENTS:	ouici	
Hyperactivity Paranoia	Suicidal Other:	•.
Hallucinating Loose Associate Manipulative	Withdrawn	
Eye Contact Lethargic	Tamified/C	
Delusional	Passive Rational	
Aggressive Irrational	. Promision	
BEHAVIORAL OBSERVATIONS		
	*	. •
Other:	Appropriate for Segregation	
Appropriate for Segregation	Speech:	
Appropriate for Segregation Orientation:	Intact	
Appropriate for r	Memory:	
Appropriate for Segregation Mood:	Within Normal Limits	
• ,	Intellectual Functioning:	
Concentration:	Appropriate for Segregation	
Appropriate for Segregation	Appearance:	7
MENTAL STATUS EXAMINATION Affect:		cal Asst. II
ALDOC Psychologist/Psychological Associate Condu	ecting Review: Brian Mitchell, Psychologic	on1" t
JO DAT REVIEW	90 DAV DEVIEW - C	
Date Review Completed: 10-4-05 Date	Placed in Segregation: 8-30-05	
	:173073 Institution: Easterling	
Inmate Name: Davi's, Ricky AIS#	EDPOTE FILE	

ALABAMA DEPARTMENT OF CORRECTIONS INMATE ORIENTATION TO MENTAL HEALTH SERVICES

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons

Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

This information on this form has been explained to me and I have received a copy of the information for my future reference.

PSYCHOLOGICAL UPDATE

Nam	ne: <u>Launilly</u> AIS#: 173673B R/S: WM
Date	: 0 /1 / 0 5 Date of Birth: 130175 Age: 263
Ir	was last evaluated by ADOC psychology staff member
Ā	A diagnosis of was made and the inmate was
re	ecommended for participation in
The f	following observations and recommendations are made as a result of the current interview
	1
l. <u>E</u>	ducational Needs
-	a. ABEb. Special Educationc. Trade Schoold. Junior College
II. <u>M</u>	ental Health Needs
	A. Refer to psychiatrist E. Sexual adjustment I. Self-concent or honoroom
	B. Substance abuse counselingF. Reality therapyJ. Healthy use of leisure
(C. Depression G. Anger-induced acting out K. Personal development
0	D. Stress management H. Values clarification
	Date referred to psychiatrist / /
III RE	ECOMMENDATIONS/REMARKS: \ \) C \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
	and the state of t
	Street million. WAD
	- MS 40 Cimnon 1.
	- ten one aceni ocer mane.
	- TO HE CON TONO.
-	
MENTA	AL HEALTH CODE: SMI HARM HIST NONE
Evaluati	on Completed by: Date: 9/4/05
1 250 A (2	

N-259 A (2/2001) White to Central Records Yellow to Institutional File Pink to Data Entry and forwarding to Medical Record

ALABAMA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES

Referred by: PSYCHIATRIC EVALUATION
Admission to Institution
Reason for Referration
NEW ADM. TO KILBY C.F. TNCAR, - 5-6-MOS.
CH - REZ. STOR. PUSP.
· · · · · · · · · · · · · · · · · · ·
matery (inpatient/outpatient/dates of text
Psychiatric History (inpatient/outpatient/dates of treatment/medications prescribed):
14 4.0, Rx- Bus Pun Fon ADHD, x + Fun, a m.d.c.
DEVIES CONNENT SP
Pertinent Medical History (allergies):
ALLERCIES-Pen
HELEKELES-PON
HEAD INJ-V
HEAD INJ - X SEIZORES - X Substance Abuse History:
Substance Abuse History:
610tt-18, POT-21, MATHEMPH 29
TX- The Aco, RostAB 1/8 x 28 dags
Pertinent Personal/Family History (inmate's sentence):
mate's sentence):
LIVING - E GINCELLOID
SOHOOL - FLAC
Institutional Adian
Par 100 - Covernet placement):
36 - ct - Poc. Srow. Prep - 5= 2 2ms/2-
91- Acc. 500, Proce - 5 3/me/ 6
School- Fhrs. Work- HAG, CONSTRUCTION Institutional Adjustment (current placement): / Pripr- 36-ck- Rec. Stor. Prep- 5= 2 has /28-9 ms 91- Acc. Stor. Prep- 5- 34RS/ 79n. JV- 15- TOFF- Days
JV- 15- TOSPI- DONI. X T WILL.
Inmate Name
Inmale Name DANIS, PICKY AIS# 173073

ALABAMA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES

PSYCHIATRIC EVALUATION
Melital Status Examination:
Appearance and Behavior: ALERT, WELL DRIENTED, APPROPLAT
Mood and Affect: STABLE IN MOOD
Speech and Language: Wんし
Thought Process:
W りし Thought Content and Perceptions:
Cognitive Assessment/Memory:
Insight/Judgement:
Sleep/Appetite:
Suicide/Violence Risk Assessment:
Past Suicidal Ideation/Attempts (dates and methods):
X
Current Suicidal Ideation and Behavior:
Beating and the second
Past Violent/Assaultive Behavior:
Current Violent/Assaultive Ideas/Behavior:
V V VIOLETIAASSAUTUVE IGEAS/BENAVIOT:
Diagnostic Impression
Axis 1: 154 87857 DEP.
Gon Maja (:Il sixA
Axis III:
Axis IV:
Axis V: 25
Treatment Recommendations (including medications/labs ordered/special housing)
Mo M. H. Sandles School D.
•
Mental Health Code: SMI HARM HIST NONE
Psychiatric Follow-Up Required Within: Days
Psychiatrist Signature Date 2/1/85
Inmate Name > Page 2 of 2
DNIS, PICKY AIS#173073

Dr. Paul Beecham MHM Correctional Services

- 07	
*1	134

	VINC
ALABAMA DEPARTMEN MENTAL HEALTI REFERRAL TO 100	Mental Health P&P # 55
DEPARTMENT	Page 2
MENTAL UEN	T OF CORPECTION
REFERDAL MEALTI	H SERVICES HONS
Inmate Name GUS COLONIA	NTALLES
4/110 10 10	TAL HEALTH
REASON FOR REFERRAL:	BUNGAB Of Referral:
TOON FOR REFERDAL	
CRISIS INTERVENIE	Date of Referral
MIERVENTIO	(200)
- IVIIIIMMA	
Record With other inmotor	_
Recent stress: Other:	
Other:	
EVALUATION OF MENTAL STATUS Homicidal	
Suicidal OF MENTAL STATE	
D Homisis	
	E 1:
U Hostile	☐ Physical complaints ☐ Sleep disturt
Other inappropriate behavior: Hostile, angry Withdrawn Poor hygiene	☐ Sleep disturbance ☐ Hallusings
"Toor hydiana	☐ Hallucinations/delusions ☐ Suspicious
FVALUE	C. Suspiciations/delusions
- TALUATION OF MEET	☐ Suspicious
EVALUATION OF NEED FOR PSYCHIATRIC EN	
HISTORY OF DO	VALUATION
OF PSYCHOTROPIO ***	TALUATION
OTHER:_	.
THER:	RIOR TO RECEPT
HISTORY OF PSYCHOTROPIC MEDICATION PL OTHER: OMMENTS:	being on MH Meds
SMINENTS: CAMAN	/ MOFER
for some bearing	1 0
MAN AN AN AN ANGUNE	the the state of
	vecno on The
Welleds " Center	Jan May Mel
Reference	and a
Referred by:	7 Curent
Referral MOUSON / Nal	1 MK
MENTAL LEAST for psychiatrist	• • • • • • • • • • • • • • • • • • • •
Referral for psychiatrist (referral has been screened by MENTAL HEALTH FOLLOW-UP: EVALUATION/TREATME	Phone Contract 2 O. /
EVALUATION SCREENED by	mental #: 684
TOATION/TREATME	Merical nealth or medical at the
	NI/DISPOSITION
	OHON
	а
SEE M. H. E	, ,
Me Milt. A	m zlilas
THE STATE OF THE S	2/1/20
Hy .	0 620
ollow-Up by:	
M/ ///	
Inmate Name	,
Jus 1	Date: 2/1/30
AIS#	
Tilly	
n. n. i.	L/31000
Dr. Paul Beecham	201/3/3

Dr. Paul Beecham MHM Correctional Services

IN RDISCIPLINARY PROGRESS NO IS

DATE	TIME	NOTES	SIGNATURE
	4.44		
W		6	
- 14N			
			•

Davis, Ricky 173073 30 W/m rulbe		Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
	1	Davis, Ricky	173073	30	1	Iulbi

A BAMA DEPARTMENT OF CORRECTA S MENTAL HEALTH SERVICES

RECEPTION	MENTAL HEALTH SCREENING	
Institutions 54 lbs 1	7 00 .	
	Date/Time Inmate Received: 1-8-65	
same of sections: 1 00 0 S	Signature/Title of Screener: L. Henderson LPN	
	•	
MENTAL HEALTH TREATMENT PRIOR :	TO ENTERING THE ALDOC:	
r sychotropic medication):	
The state of the s	to ALDOC upon arrival?	
weard teath tollow-in	in last 00 down	
/ A DOLL HOLLIE ALCOHO	ots in last 90 days:	
MENTAL HEALTH HISTORY Does immo	Ole portry a high-law of the E. H.	
Tes No Outpatient treatment:	ate report a history of the following (if yes, provide details):	
Yes No Inpatient treatment:	1010 91 8 b	
Yes No Psychotropic medication:	Kotalen - 16-15 (no -	
11 Yes 14 No Suicidal attempts:	707391390	
U Yes U No Suicidal thoughts:		
	Clother + - Klycar	
Yes I No Violent behavior: No Substance abuse:	47	
Yes il No Substance abuse treatment	J 7091591V	
Ves No Special education classes:		
'	n squar I d	
INMATE SELF-REPORT OF CURRENT ST	CATTION Q	
LINE OF NO Parel management	and Industry	
LINO Reports family supports	MA CONTOCOLT	()
I res ti No Reports serious depression	premorse: (Carpenter	
Thinking about suicide:		
U Yes U No Has plan for suicide:		
O Yes to No Possible to implement plan	1:	
U Yes To No Reports hallucinations:		
BEHAVIORAL OBSERVATIONS:		
Poor eye contact Poor hydrena	Unable to pay attention Unresponsive	
LI Disoriented Overly anvior	Diresponsive University	
☐ Memory defic	icits [] Signs of self-mutilation [] Acres	
The state of the state of the state of the	C hearing voices or seeing things	
☐ Hostile ☐ Other unusual	I behavior:	
DISPOSITION/ PLACEMENT RECOMMENT	DATECON A.	
O Routine housing and mental health follow-up	DATION (based on reception mental health screening):	
Circuity mental health follow-up but not amount	Barray manner invested (Clessian	
Current psychotropic meds verified/interim sup	ency Safe cell placement recommended Deply ordered Parole violator interim assessment referral	
	The state of the s	
1)	
Inmate Name	AIS# (AB)	7
LYUD, A C	CKY 11/30/130	
(/ (ALDOC Form 450-01	_

4 of 6



YEARLY HEALTH EVALUATION

\bigcap I.	HISTORY – (LPN or RN)	YES NO	COMMENT(S)
	Weight Change (greater 15 lbs.) (Compare Weight Below) Persistent Cough Chest Pain Blood in Urine or Stool Difficult Urination Other Illnesses (Details) S:noke, Dip or Chew ALLERGIES		Last weight at least 6 months ago Part hx 1/2 play
Weigh Eye Ex	nt 180 Temp 98 Pulse 98 xam 20 20 20 20 20 20 00	If greater than	Pressure 108 B-17 > 140/90, repeat in 1hour. B-17 if remains > 140/90.
II.	TESTING - (LPN or RN)	RESULTS	
e e	Tuberculin Skin Test (q yr) Past Positive TB Skin Test (Chest x-ray if clinical symptoms) →	Date given 1-14-66 Read on 1-14-24 Re Survey Completed Date Re	
•	RPR (q 3 yrs) EAG (baseline at 35, over 45 q 3 yrs) Cholesterol (at 35 then q 5 yrs) Tetanus/Diptheria (q 10 yrs) (if done today) Optometry Exam (@ 50 if not already seen) Mammogram (females @ 40, q 2 yrs/other M.D. order)	NIA NIA Last Given 2064	Due 2014 Due 2014 Due 2014 Due 2014 Due 2014
<u>III. </u>	HYSICAL RESULTS — (RN, Mid-Level, N	M.D.)	
. I. R	with Hemoccult	RRR Clav bi General EU EYam explain Results DIA Results NIA Date Resu	od-Volved undastand
Facility_	Easterlig Nurse Signature MCKi	nnon C	Date 1-14-06
M.D. or	lid-Level Signature	· · · · · · · · · · · · · · · · · · ·	Date 11706 RACE/SEX
Davis.	Ricky 173073	1-30-75	WIM



DEPARTMENT OF CORRECTIONS

NOTIFICATION OF NEXT OF KIN

In the event of a serious injury or illness, I request the following person be notified:

11

10.0.10
11011
Relationship
^
Phone Number Phone Number
350/6 Zin Code
Phone Number
Λ
Ht (256) 586-0068 oc(256) 572-943°
The state of the s
State Zip Code
173073 547-79-7616 M/20/05
AICH CON TOP CHOCK
AIS# SS# Date
ρ_{A}/ρ_{A}
29KU 01/29/05
1/10/
Date '

INMATE NAME (LAST, FIRST, MIDDLE)	AIS#	D.O.B.	RACE/SEX	FACILITY
Davis, Ricky	13013	01/30 [975]	WM	KCF

INTAKE HEALTH EVALUATION

NAME: <u>Davis</u>, <u>Ricky</u> AIS#: <u>173073</u> D.O.B.: 1-38-75

	Age 30 Sex	M		Race W	Heigl	nt S	Weight /6 Resp: /6 d-Level if B/P remains	 (a)	
	Temp: 98.1	B/P:	1/0)/60 Pulse	: 64	4	Resp. 16	90	
	** B/P – If greater	than	140	/90, repeat in 1 hour. R	efer t	o Mi	d-Level if B/P remains	up.	
				ver had, or been treated for:					
	20 you now of 1	iave .	you <u>e</u>	ver had, or been treated for:		7SB	S-77		
	Problem	1		N Problem	Y	′ N	Problem	Y	N
	Head Trauma			✓ Gastritis		V	. 10010111	+	17
	Loss of Consciousness		╽.	Ulcers				+	+
	Severe Headaches	1	<u> </u>	/ Bleeding	- -	1	***Medications Verified	_	-
	Vertigo/Dizziness	T	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	/ Gall Bladder/Pancreas		1	Hepatitis - Type	ـــــ	1
	Vision Problems	1	1.	Liver Problems	-		Gonorrhea	╁	/
	Hearing Problems	 	1 6	Arthritis	+-	1	1-71	ـــ	/
	Seizures	1				+-	Lice, Crabs, Scabies	┼	1
	Strokes		1	Back/Neck Problem	+-	1	1140	 	
	Nervous Disorders		1			 	LMP	 	<u> </u>
		1	1	Bladder/Kidney	+	1	Date		
	DT's		1	Infection			Duration		
	Heart Condition		1	Alcoholism		/	Normal		
	Angina/Heart Attack		1	Drug Abuse	1		Regularity		
	High Blood Pressure Anemia/Blood		<u> </u>	Psychiatric History		/	Gravida/Para		
	Disorder		1	Suicidal Thoughts**			ADVA		
	Sickle Cell or Trait			**Immediate M.H. Referral	 		AB/M/scarriage	-	
	Lung Condition			T.B.			Contraception		
	Asthma *			PPD - date given: 1/3	1/00		Type:	\dashv	
	+D 1 E1 E				1103			\dashv	
ŀ	*Peak Flow Reading		(RFADFA			Lab Tests - Dates	N	Ab
-	Bronchitis		V	Date read: 2-3-05			Diagnostic Profile II		
+	Emphysema		V	Results. Omm			RPR		
-	Pneumonia		1	Visual Acuity			Urine Dip Stick		
	Diabetes		/	OD OS					
	Hay Fever/Allergies		1	OU 20/20			EKG (@ age 35)		
Iı	mmunization History: To	6	2000	t - Stated Cer	11018	4	Stated		
	nmunizations Needed:				vare	<u> </u>	3/2/00		
	**HIV Medications:					<u>-</u>		-	
A	oute on Chaon: D. 11			. 🔿					
A	cute or Chronic Problem N	oted	: }	N Refer to M	id-Le	vel or	M.D. if yes.		
_	W. Deagan						1131105@ 11:20	7	
R	N or Mid-Level, Signa	ture	:		Da	te/Ti	ime		_

Case 2:06-cv-00010-MEF-TFM Document 21-2 Filed 03/06/2006 Page 32 of 100

I have read the access to health care information sheets and have been given a copy. I understand how to

AIS#

INTAKE HEALTH APPRAISAL Case 2:06-cv-00010-MEP-1FM	Docu	menN2ME: <u>Fled 03</u> AIS#:	<u>/0@24</u>	206 Page 33 of 100
		D.O.B.:		R/S_w/w
HEAL MILES AND		APPRAISAL	N	I Abn/Comment
HEALTH CLASSIFICATIONS: (Circle One) 1 No Restrictions	Gener	ral Movement Deformity Pain, Bleeding Habitus, Hygiene	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	, ambulates 3 dy
2 – Temporary Restrictions See Special Needs Form	Neuro	Mental Status Intox Withdrawal, Tremor Neuro-Deficits	V	AA-OX3
3 – Permanent Restrictions See Special Needs Form 4 – A&I (Aged & Infirmed)	Skin	Injury, Bruises, Trauma Jaundice Diaphoretic Rash, Lesions, Infestations Needle Marks Color, Turgor		Tattoos-multiple scare-&
5 - Not Determined Recheck	Head	Normocaphalic Atraumatic Hair, Scalp	1	WNL
PLACEMENT:	Eyes	Glasses/Vision Pupils Sclera, Conjunctiva	1	PERRUA
General Population Emergency Department () Isolation	Nose	Appearance Canals, TMs, Hearing Epistaxis	1	WILL
Medical Observation () Other	Throat	Sinuses Teeth, Gums, Dentures Mouth, Tongue, Tonsils Airway	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	WAL
REFERRAL: CCC Placement ()	Neck	C-Spine, Mobility Veins, Carotids Thyroid, Lymph Nodes	V	Supple, full nom
Clinic(s) See MD/Mid-Level flow sheet for clinic(s).	Chest	Config. Ausc/Resp Cough/Sputum Breast/Masses	1	lungs CTH below
Medical () Dental ()	Heart	Ausc Rate, Rhythm Murmurs, Ectopy	1	Her
Mental Health () Other	Abdomen	Bowel Sounds Palp, G/R/T, Hernia	V	Soft, non-duit @BSX4
When: () Immediately () Next Sick Call	GU Blac	Flank Tenderness Ider Tenderness/Distention	1	lunc
() A TOME DADIE CALL	Back	ROM, Spasm, Injury	<u> </u>	full Rom
MMUNIZATIONS ORDERED:	Genitals	s Edema, Pulse Injuries/Lesions	7	MAEW

Medications Ordered: _ M.D. or Mid-Level Signature

Rectal/Guiac (required @ 45 and up) Deferred/follow-up:

Date/Time



PRISON	
HEALTH SERVICES NEORPORATED	
INTAI	KE SCREENING
Date: 0/12-90 105	AIS#./73.07=
	AID#.// 3073
Last Name: Daylis First:	Big Middle: \ /2
Birthplace: Relatort, Tenn DOB.	1)1, On, y wade
Bittiplace. () e/actory (e/) y DOB:	81/30/1975 SS#: 587-29-78/8
	, ,
FEMALES: Pregnancy test:	B/P / Pulse Resp. Weight
(circle one) Positive Negative	1 11 766 901 717 70 160
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1
Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? V	Vhere?
0	
Previous Incarcerations (Date & Facility)	
1991 KOT	
Medications: None	
Allergies: NKA DA A	Special Diet (Prescribed)
	Past Positive TB Skin Test (circle one) YES - (Complete TB Screening Form)
ANY INMATE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY B	FEDING IN ACUTE DAIN AND UDGENTLY IN MEED OF MEDICAL
ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY	CARE.
CLINICAL O	BSERVATIONS
1) Level of Consciousness () Alert () Oriented; time, place, person	3) Substance Abuse: () No () Suspected
() Lethargic () Stuporous () Comatose Describe:	() Current intoxication/Abuse () Use () Withdrawal Symptoms
	Describe- What kind? Amount/Frequency? May wana
2) General Appearance ()Normal () Abnormal	
3) Signs of Trauma () Yes () No	 If confirmed Benzo use, then call M.D. If can not be confirmed, call M.D.
	Last Use: (Time(Date):
4a) Behavior/Conduct: (Calm (Cooperative () Non-Violent	4b) Affect/Mood: () Normal () Manic () Depressed
() Agitated () Uncooperative () Violent	() Euphoria () Flat () Emotionally Confused
() Manipulative () Disorganized Describe:	
	Describe:
4c) Perceptions: () Delusional () Hallucinations	() Hearing Voices
	() Houring voices
5a) Is there h/o actual suicide attempt? () Yes + No 5c) Is there evidence	5b) Does pt describe current suicidal thoughts or ideations? () Yes () No
	5d) High risk pt may become assaultive towards staff? () Yes () No
If ANY of the above in #5 are circled, staff MUST describe here, include previous history and dates:	Triggers for Suicide Watch - Currently Suicidal - Emotionally distraught and unable
•	- Currently Suicidal - Emotionally distraught and <u>unable</u> - History of <u>actual</u> attempt to regain composure by end of
*Any abnormal observations #4 or 5 require immediate Mental Health	- Fails to maintain control on intake process
Referral.	Close Watch Y or N - Actively hallucinating or not
a) Communication Difficulties () Yes + No _	making any sense Y or N 6b) Memory Defects () Yes +TNo
c) Hearing Impairment (1) Yes (1) Yes	Cd) Create Diff. III
7) Physical Aids: () None () Glasses () Contacts () F	learing Aid () Dentures () Cane () Crutches
() Walker () Wheelchair () Braces () A	Artificial Limb () Other
A Comment of the Comm	
S)	
0) Fever Y N Swollen Glands V AT	
0) Fever Y (N) Swollen Glands Y (N	Signs of Infection Y (N) Skin Intact Y N
A)	
P)	
If known Diabetic * Call M.D. for order	Initial Insulin given:
I have answered all questions truthfully. I have been told and shown he	
Have been told and shown ho	w to obtain medical services. I be reby give my consent for

health services to be provided to me by and through PRISON HEALTH SERVICES.

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATE NAME Davis, Ricky
Medication Allergies: PCN (wh)
Medical: Chronic (Long-Term) Problems Roman Numerals for Medical/Surgical
Mental Health Code: SMI HARM HIST NONE

Health Code: SMI HARM HIST NONE

Capital Letter for Psychiatric Behavior

Date Identified	Chronic Medical Problem	Mental Health Code	Date Resolved	Provide Initials
9/1/5	5 PPD- pmm Folliarly Canadas			n
	12/22/05 Rep. B Vacc. #1 12/22/05	Hep. B Vacc. #2 BVB004BA 20/2006		4
				-
ς .				

^{**}If Asthmatic label: Mild – Moderate – or Severe.

Hepatitis B Vaccine on Sent 100 Form

FACILITY NAME Easterling Correctional Facility

RICKY DAVIS	W/173073	
Inmate Name	AIS Number	
Inmate Signature	<u> 12-22-05</u> Date	
Dose Given 20 mg. (1 ml) / 2 nd dose	
Site Given B deltoid	/	
Administered by	MPaegne Par	
Administered by	1111 tax 100 100	

Lot Number and Expiration Date AHBYBOOHBA

Hepatitis B Vaccine Consent Form

FACILITY NAME East	eslina	
RICKY DAVIS	173073	- DOB
Inmate Name	AIS Number	1/30/75
RICKY DAVIS	11-22-05	-
Inmate Signature	Date	
Dose Given 1 ml.		
Site Given Ddeltoid	Y	
Administered by	Payre Por	
Lot Number and Expiration D	Oate_ Lot# AHBV EXP. 01/2	

11/21/2005



DEPARTMENT OF CORRECTIONS

DENTAL RECORD TREATMENT

	Tooth #				
Date	Tooth #	Diagnosis			
			Treatment		
				Initials	C
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NT LAS	T NAME	FIDOT			
		FIRST	MIDDLE		
			DOB R/S	ID NO	7
				ID 110.	
7-70022			ļ ļ		1



PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: DAVIS Ricky BCDC#: 173073

- 1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.
- 2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.
- 3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.
- 4. I have had the opportunity to ask questions which have been answered to my satisfaction.
- 5. I understand there is no guarantee of success or permanence of the treatment.

Patient's Signature

Date

Dentist's Signature

Date

DENTAL EXAMINATION

RESTORATIONS AND TREATMENTS

DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

DENTAL RECORD

Date of Initial Ex	amination	26 25 24 23 22 23 1 - 0 5		Initial (i 2 31			
		gy	Gingivitis					
	Occlusion	<i>ay</i> ************************************	Vincent's Infe Stomatitis Other Finding					
		ame						
		ams	Periapical Bitewing Other					
Health Question	naire							
YES NO TO	Rheumatic Allergy (No Present Me Epilepsy Asthma Diabetes HIV	vocaine penicill	n)etc.)	YES	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	V.D. Hepatitis Anemia or Bleedin Heart Disease High Blood Pressu Kidney Disease Other Disease	- (
			SERVICES I	RENDE	RFD			
Date 05	Tooth #	DX CC.	solut gyns;	A P		HA hAD A	Initials	Class
111111111111111111111111111111111111111								
INMATE NAME (IDDLE)			DOC#	DOB	R/S	FAC.
DAVIS,	Rick	 		ľ	13073	1/30/15	W	FAC.
HS-MD-70015		1				·/ L		

MT. MEIGS, AL 36057

PATTENT NAM PRISON II

DATE SUBMITTED

	-		
TEST NAME	RESULT		NPY 19
HIVANT		REFERENCE RANGE	COMMENTS
HIV ANTIBODY	NR -	Aller	
		NEGATIVE (NEG)	
RPR	NR		
		NON-REACTIVE (NR)	
URINALYSIS	NEG	+	
APPEARANCE		H _S	
рH	 	18	
PROTEIN		pH 5- pH 6	
GLUCOSE			
KETONES		NEGATIVE (NEG)	
		NEGATIVE (NEG)	
BILIRUBIN		NEGATIVE (NEG)	3
BLOOD		NEGATIVE (NEG)	
NITRITE		< 5 RBC/MCL	
UROBILINOGEN		NEGATIVE (NEG)	
LEUK, ESTERASE		< 1.0 MG/DL	
SPECIFIC GRAVITY		NEGATIVE (NEG)	
These results are un		1.016-1.022	
The courts are un	reliable J		

 $^{\rm n} A^{\rm n}$

These results are unreliable due to the age of the specimen.

"H" "A+H"

These results are unreliable due to the hemolyzed condition of the specimen. These results are unreliable due to the age and hemolyzed condition of the

Case 2:06-cv-00010-MEF-TFM Document 21-2

Filed 03/06/2006

Phone: 334-263-5745

ADCOTO LabCorp Montgomery Hull

543 Hull Street, Montgomery, AL 36104-0000

SPECIMEN PRIMARY LAB | REPORT STATUS TYPE 031-684-3172-0 COMPLETE Page #: ADDITIONAL INFORMATION NPY-19 FASTING: N DOB: 1/30/1975

PATIENT NAME SEX AGE(YR./MOS.) DAVIS,RICKY M 30 / PT. ADD.:

DATE OF SPECIMEN TIME DATE RECEIVED DATE REPORTED TIME 1/31/2005 6:00 1/31/2005 1/31/2005 17:11 2574

CLINICAL INFORMATION CD-41139313263 PHYSICIAN ID. PATIENT ID. ROBBINS M 173073 ACCOUNT: Kilby Correctional Facility Prison Health Services 12201 Wares Ferry Road Mt. Meigs AL 36507-0000 ACCOUNT NUMBER:

01306900

TEST		ACCOUNT	NUMBER: 01306900	1
	RE	SULT	LIMITS	LAB
CBC With Differential/Platelet White Blood Cell (WBC) Count Red Blood Cell (RBC) Count Hemoglobin Hematocrit MCV MCH MCHC RDW Platelets Neutrophils Lymphs Monocytes Eos Basos	7.7 5.06 15.6 44.5 88 30.9 35.1 12.8 200 56 33 6	x10E3/uL x10E6/uL g/dL % fL pg g/dL % x10E3/uL % %	4.0 - 10.5 4.10 - 5.60 12.5 - 17.0 36.0 - 50.0 80 - 98 27.0 - 34.0 32.0 - 36.0 11.7 - 15.0 140 - 415 40 - 74 14 - 46 4 - 13 0 - 7	YX Y
Neutrophils (Absolute) Lymphs (Absolute) Monocytes (Absolute) Eos (Absolute) Baso (Absolute)	4.3 2.5 0.5 0.2 0.2	x10E3/uL x10E3/uL x10E3/uL x10E3/uL x10E3/uL	0 - 3 1.8 - 7.8 0.7 - 4.5 0.1 - 1.0 0.0 - 0.4 0.0 - 0.2	YX YX YX YX YX YX

LAB: YX LabCorp Montgomery Hull

DIRECTOR: Alton Sturtevant B PhD

543 Hull Street, Montgomery, AL 36104-0000

Pat Name: DAVIS,RICKY

Pat ID: 173073

Spec #: 031-684-3172-0

Seq #: 2574



Case 2:06-c/-00010-MEF-TFM Document 21-2 Filed 03/06/2006 Page 43 of 100 Oug -
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Start Date: 12/5 Prescriber: DONOUZC Stop Date: 12/19 RX#:
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Start Date: 12 5 Prescriber: Danosing
Stop Date: 2/10 RX#: Hour 1 2 3 4 6 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 Bid x 5d.
Stop Date: 12/10 RX#: Ri Pampin 300ng = po Na Na Na Na Na Na Na Na Na N
Ri Pampin 300ng = po Ha 300ng = po hid x 10 days
Start Date: 12 13 05 Prescriber: Darbuce Wf Stop Date: 12 23 05 RX#: Backing Ds 7 00 Did Harman Ds 7 00 Did
Bactrine DS - po bid Ha 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 X 10 daep
Start Date: 12/13/05 Prescriber: Dir DOLCU /Uf Stop Date: 12/23/05 RX #: Hour 1 2 3 4 5 6 7 8 9 10 11 12 14 2 14 15 16 17 8
PRN & 3 darp
Start Date: 12 13 05 Prescriber: Darbouze UP Stop Date: 12 16 05
Allergies Nurse's Signature Initial Nurse's Signature Initial Documentation Codes 1 Discontinued Order 2 Refused
Housing Unit: Patient ID Number: Patient Name: 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication out of Stock
Date of Birth: 130 75 8 Medication Held 9 No Show 10 Other

	Case 2:06-cv-00010	-MEF-TFM Docume		i	Page 44 of 100
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-	per 4 3 day		305 Prescriber,	arbouze [n	
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		Start Date: Stop Date:	Prescriber:	:	
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		Start Date:	Prescriber:		
·		Stop Date:	RX#: 8 9 10 11 12 13 14 15 1	6 17 18 19 20 21 2	22 23 24 25 26 27 28 29 30 31
		Start Date:	Properitor		
Diagnos	Sis	Stop Date:	Prescriber:		A salier to the
Allergie	No. 1	Nurse's Signature	Initial Nurse's Si	gnature Initi	1 Discontinued Order 2 Refused
Housing Patient I Patient N	D Number: (130 1)		5.5	A Sh	3. Patient out of facility 4. Charted in Error 5. Lock Down 6. Self Administered 7. Medication and the self-self-self-self-self-self-self-self-
	Davis, Ri	CKV T	Date of Birth:	1/20/179	7 Medication out of Stock 8 Medication Held 9 No Show 10 Other

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Case 2:06-cv-00010-MEF-TFM	Document 21-2	Filed 03/06/2006	Page 45 of 100
FASTERING Hour 1 PFC BID X 14day Up	2 3 4 5 6 7 8 9	Month/Year of Charting: 10 11 12 13 14 15 16 17 18 19	20 21 22 23 24 25 26 27 28 29 30 31
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	t Date: 4-3-05 - Date: 9-110-175	Prescriber: Lenbou	12e
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dy 1	PRO	89/16	20 20 30 31
Start of Stop Date	The state of the s	escriber: Our Duze	
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			20 20 00 01
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Hour 1 2 3		RX #: 12 13 14 15 16 17 18 19 20 21	22 23 24 25 26 27 28 29 30 31
			20 20 30 31
Start Date:	Presc	iriber:	
Diagnosis Stop Date:	nature Initial	RX#:	
Allergies	mp	Nurse's Signature Ini	tial Documentation Codes 1 Discontinued Order 2 Refused
PCN HATI depressent & blage Housing Unit: Patient ID Number:	till in in	Inlane & f	3 Patient out of facility 4 Charted in Error 5 Lock Down
Patient Name:) (e.		6 Self Administered 7 Medication out of Stock 8 Medication Held
Davis Ricky 17307	0	Date of Birth: 1-30-70	9 No Show

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STDT01			
MEDICATIONS	HOUR 1 2 8 4 5		
Bactrim DS			[ES 2012] 22 25 24 25 26 27 28 22
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5/5/05 5/15/05 Darbouze			
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5/5/05 5/15/05 Darbouze			
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MEDICATIONS	HOUR 1 2 3 4 5 6	7 8 9 10 11 12 13 14 15 16 17 18 19 2	20 21 22 23 24 25 26 27 28 29 3
	THROUGH 500	D INSTRUCTIONS ON REVERSE SIDE	
Physician NOWOUTO	THROUGH 505	Telephone No:	
Alf. Physician		Alt Telephone	Medical Record No.
yergies PCN		Rehabilitative Potential	
lagnosis .		Potential	
the state of the s			
edicaid Number Medicare Number	Complete Entries Checked.		· · ·
ATTENT	By GRawkins	Title: 1000 PATIENT CODE 173073	Date 5 FAC
Davis, Ricky	· 1988年,在1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年,1988年	1173073	BED FAC



Nature of problem or request: I have And I have A long lung the one's in Arm's thirt And my Guns togotopological Swellen And Hurt And Bleed	RICKY WAde DAVIS Signature	
DO NOT WRITE BEI	LOW THIS LINE	
Date:/ AM PM Allergies:	RECEIVED Date: Time: Receiving Nurse Intials	
(S)ubjective:		
(O)bjective (V/S): T: P:	<u>R:</u> <u>BP:</u> <u>W</u> 1	Γ:
(A)ssessment:	Met	
(P)lan:	1/11/2006	
Refer to: MD/PA Mental Health Dental Dail CIRCLE ON Check One: ROUTINE () EMERGENCY () If Emergency was PHS supervisor notified: Was MD/PA on call notified: SIGN	NE	
WHITE: INMATES MEDICAL FILE YELLOW: INMATE RETAINS COPY AFTER NURSE	E INITIALS RECEIPT	

GLF-1002 (1/4)

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2			Z

Nursing Evaluation Tool: **Dental Complaint** Facility: Patient Name: Inmate Number: Date of Birth: Date of Report: Subjective: Chief Complaint(s): Dwollen and hurtand bleed." ano History: NEUCY (Continue on back if necessary) Check Here if additional notes on back Injury sustained in altercation with custody staff, or other inmate: QNO Q YES (Require's notification of correctional staff) Dental Pain: Right: ☐ Upper Back ☐ Upper Front ☐ Lower Back Left: ☐ Upper Back ☐ Upper Front ☐ Lower Back *Lower-trant Type of Pain:

Aching

Throbbing

Dull

Sharp

Constant

Intermittent ☐ Lower front Sensitive to Hot or Cold: No Hot Cold Sensitive to both Hot & Cold Pain Scale: (1-10) Associated Symptoms:

Sinus problems

Difficulty chewing

Earache

Sore throat

Other: Objective: Vital Signs: (If Indicated) T: Visual evidence of tooth decay/fracture No M ☐ Yes Visible external swelling Visual evidence of missing filling DYNo. ☐ Yes O No Q Yes Swelling/redness/pus surrounding affected tooth: Pain upon opening jaw widely 1 Na O Yes ON No Q Yes Evidence of trauma/injury to jaw/face ☐ Yes ON YO ☐ Additional Examination: Continue on back if necessary) Assessment: (Referral Status) Check Here if continued on back Preliminary Determination(s): Referral Not Required Referral Required due to the following: (Check all that apply) D Evidence of pus collection or swelling ☐ Earache/sore throat/sinus problems Recent dental surgery/procedure Pain upon opening mouth widely Significant injury/trauma to jaw ☐ Recurrent Complaint (More than 2 visits) Other: (Describe) Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the For tooth pain; instruct patient to avoid hot/cold food; to chew on the opposite side of the tooth pain and to do salt water gargles PRN

Plan: Sheck All That Apply:

☐ Warm rinses PRN (Note: <u>DO NOT</u> apply warm compress to outside of face for dental abscess)

O Cold Compress PRN for minor trauma Instructions to return if condition worsens.

Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do as well as appropriate follow-up. YES DNO (If NO then schedule patient for appropriate follow-up visits)

Other: (Describe)

OTC Medications given NO DYES (If Yes List): Referral: O NO DYES (If Yes, Whom/Where): West

Referral Type: Routine Urgent D Emergent (if emergent who was contacted?):

Nursing Evaluation Tool:

General Sick Call

	Facility: ECF DOUIS RICKI
	Inmate Number: 17207 dast First () 1 20 10 ML
	Date of Birth: 1 / OUT 1/3
	Date of Report: 1 1 1 0000 Time Seen: 45 AM/PM Circle One
<u>S</u> u	bjective: chief complaint(s): I got 2 knots on my Dammand one on my () Onset: about a ugar.
D.	
	rief History:
	O Check Here if additional notes on back
<u>O</u> bj	ective: Vital Signs: (As Indicated) T: 18 P: 10 RR: 18 B/P: 136 / 80
Exa	amination Findings: Kmoto alt on Danm and on starmal
(Con	runue on back if necessary)

Asse	essment: (Referral Status) Preliminary Determination(s):
0.04	Referral NOT REQUIRED
	Referral REQUIRED due to the following: (Check all that apply) Recurrent Complaint (More than 2 visits for the same complaint)
	Other:
	Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.
Diam	· · · · · · · · · · · · · · · · · · ·
<u>P</u> lan:	Check All That Apply: ☑ Instructions to return if condition worsens.
	Execution: The patient demonstrates an understanding of the patient of the patien
	as well as appropriate follow-up. YES NO (If NO then schedule patient for appropriate follow-up visits) Other:
отс	(Describe) Medications given ☑ NO ☐ YES (If Yes List):
	ferral: D NO DYES (If Yes, Whom/Where): DOF DOLL D Date for referral: 34, 3006
(Ne)	ferral Type: Routine Urgent Emergent (if emergent who was contacted?): Time
	Name: Name:
	Nurses Signature Printed



Print Name: RICKY WAde DAVIS ID # 123073 Date of Bird Nature of problem or request: I Went Ar And He Put me on some Creat And I have use the problem of the Broke out in A Bad	vd Sean the m For Day it 3 Time BASH Broky	acation & B	5 11 e 12/6/05 mas has
DO NOT WRITE BEL	OW THIS LINE	oignature.	
Date:/ Time: AM PM Allergies:	RECEI Date: DEC Time: Nurse	8 27/3	
(S)ubjective:			
(O)bjective (V/S): T: P: (A)ssessment:	<u>R:</u>	BP:	WT:
(P)lan:			
Refer to: MD/PA Mental Health Dental Daily CIRCLE ON Check One: ROUTINE() EMERGENCY() If Emergency was PHS supervisor notified: Was MD/PA on call notified:	E		RN
			· .
SIGN	ATURE AND TIT	TLE	

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

PHS

	Munation -	
Facility: ECT	Nursing Evaluation Tool:	Ďamo du
Patient Name:		<u>Dermatitis (Rashes)</u>
Inmate Number:_	Devis, KIKY	
Date of Report:	FIRST	
Troport.	MM = 30	1 130175 MI
	Time Seen: 9 (AM / PM Circle One
Subjective: Chief Complete		
- mor compla	int: Oltching OBurning ORedness OSwelling OWeeping OF	
Onset: U.C.	Sterda :: Denies any of a hard	Blisters Lice/Scabies/Nits
Location: (D)	Sterday of a bore sy	imptems
History: States	the hours	
(Continue on back	kirnecessary) From Mycolog Cre	
Associated a	n gaily cre	am given for
symptoms: D-k	Tongue Swelling/Tots (allergens/Irritants):	
Recent environment	ifficulty breathing Other:	Check Here if additional notes on back
History of new medication	cts (allergens/Irritants):	acial/Neck Swelling
0	gwing.	
Objective: Vital Signs: (If I	ndicated) T: 978 P: 68 RR: 20	
Lidin: Lesion/elvi	DNG	116,81)
☐ Additional Examination:	Paking: O NO DESCRIPTION: MULTIPLE red, vaised, b.	listers to (1)
Continue on back if necessary)		
Assessment (D.		
Assessment: (Referral Status) Referral NOT Required	Da. 11 4	\
Referral Required reference	Preliminary Determination(s): Dic My Co	Check Here if continued on back
Respiratory distres	" · · · · · · · · · · · · · · · · · · ·	olog omtment per s reaction
☐ New medication	Tongue or facial swelling	Colle
(Describe)	Signs of infection Recurrent Complaint (More than 2)	visits)
Lidii: Check All That A		
— meds given per approved OTC med	d list: 🗖	
Education: The nations do	Q	
well as appropriate follow-up OVES	s an understanding of the nature of their modical	
immediate medical attention if these	s an understanding of the nature of their medical condition and instructions NO (If NO then schedule patient for appropriate follow-up visits) svere allergic reaction: (Difficulty breathing, throat or facial swelling). Pt inst YES (If Yes List):	regarding what they should do an
Other OTC Medications given	should occur. The should be strong throat or facial swelling). Pt ins	tructed to seek immediate
Referral: I NO YES (If Yes, Whom/	Where):	a 200K milleulate seek
Routine Urgent U		erral: 12-12 , >2
CIDA MADER		erral: 12/13/05
Nurses Signature P	Name: CNambles PR	Time
	Printed Printed PA	
		<u></u>

Nursing Evaluation Tool:

General Sick Call

	Facility: ECF
	Patient Name: Davis Richard
	Inmate Number: 173073 Date of Birth: 1 30 175 MI
	Date of Report: (/ 1 Zr 105
	Time Seen: 9:10 AM PN Circle One
<u> </u>	bjective: Chief Complaint(s): Doves wide pasal passage
	Onset: 2 whs
İ	ef History: At C/o dry factory Cracking meas inside varies at stille
-	Hers sub over but will bled when the first
-	they planty his note
_	
<u>O</u> b	ctive: Vital Signs: (As Indicated) T: 96 P: 64 RR: 14 B/P: 104 / 64
E	mination Findings:
(Cc	nue on back if necessary)
· · · · · · · · · · · · · · · · · · ·	
Ass	sment: (Referral Status) Preliminary Determination(s):
	A REPURED
· · · · · · · · · · · · · · · · · · ·	Referral REQUIRED due to the following: (Check all that apply)
	Other: Answerseld by Many Hall
	2 miles of miles
	Comment: You should content as Levi
	Comment: You should contact a physician and/or a nursing supervisor if you have any concerns about the status of the patient or are unsure of the appropriate care to be given.
<u>P</u> lan:	Check All That Apply:
	Instructions to return if condition worsens. Education: The patient demonstrates an understanding of the peture of the peture of the peture.
-	Education: The patient demonstrates an understanding of the nature of their medical condition and instructions regarding what they should do other:
OTC	(Dec. 1)
010	edications given NO PES (If Yes List):
Re	ral: O NO XYES (If Yes, Whom/Where): MO Date for referral: 1 / 28/ 05
Kei	ral Type: Routine Urgent Demorgent (if emergent who was contacted?): Date for referral: 1 / 28 / 03 MM DD YYYY Time
	Name: Name:
	Name:
	$\ell \setminus I$



Nature of problem or request: the	Date of Repair Date of Repair Date of Birth: 1-30- 2N 5, de of repair Date of Part Date of Repair Date of Date of Repair Date of Date of Date of Repair Date of	75 Location: 5	7/05 -B-11 15
DO NOT WI	Lioky RITE BELOW THIS L	Niche Day) Signature INE	3
Date://_ Time: AM PM Allergies:	Date: Time:	ECEIVED	
(S)ubjective:	L		
(O)bjective (V/S): T: P:	<u>R:</u>	BP:	<u>WT:</u>
(A)ssessment:		Λ ΛΩ / /	
(P)lan:		JUNE!	
	IRCLE ONE	Return to Clin	id PRN
Check One: ROUTINE () EMERGI If Emergency was PHS supervisor was MD/PA on call results.		No () No ()	
	SIGNATURE AN	D TITLE	

WHITE: INMATES MEDICAL FILE

YELLOW: INMATE RETAINS COPY AFTER NURSE INITIALS RECEIPT

GLF-1002 (1/4)



Print Name: Ricky Wade DAVIS Date of Request: 4/2/05
ID# 173673 Date of Request:
ID# 173073 Date of Birth: 1/30/75 Location: 5-B-1cell Nature of problem or request: my neck is Broke out pant
and my feet are to
- CET WE 10
Kin Kil I Aug
Signature Signature
DO NOT WRITE BELOW THIS LINE
Date: \$ 12,05
Time: USIS AV DO
Allergies: PCN Julidepenants Date:
Time:
Receiving Nurse Intials W
(S)ubjective:
(S)ubjective: I I asked HC crean and it got worser " "Longs weel the artifugal crean for Zdays"
and the state of the works
the original creat for Edays
(O) bjective (V/S): T: 97 P: 67 R: 14 BP: 82 WT: 172 ADX3, skin warm and dry - pt has multiple lessions on R port seckie Djan line, pt % interse ittly and condition worsered when AL 100 Cream from, counter woo used, pt also "b continued px c (A) ssessment: attletes fort fungura, Micropyle gave which in the post purpo alt in skin integrity
AADV3 ON: 17 BP: 18 WT: 17d
where Driver at the state multiple lesions on (R) port
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GLF-1002 (1/4)



Print Name: Ricky Wade Davis Date of Request: 8/26/05	
Date of Birth: $1-30-75$ Location: $10-35$	
Nature of problem or request: My Neck is Broke out and	
it Hurt's And my Foot is Broke out to Thank's	
Kirky Wade DAVIS	
DO NOT WRITE BELOW THIS LINE	
- 4 x/b	
Date: 0 100 75 Time: RECEIVED	
Allergies:AM PM RECEIVED Date:	
Time 26 205 Receiving Nurse Intials	
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GLF-1002 (1/4)



GLF-1002 (1/4)

PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

21/2. 10:	
Print Name: Ricky wade Down's ID # Date of Bir Nature of problem or request:	Date of Request: .5/.3/05
$1D # _ / / 3073^{\circ}$ Date of Bir	th: \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\
Nature of problem or request:	
- I have a SPIDER BITE	OR CIST, OR STAF INFECTION
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Neey to see The DOCTOR	Oli
·	Kinkel DACUS
	Signature
DO NOT WRITE BEL	OW THIS LINE
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Date: 2 / 7/00	
Time: 85AM PM	RECEIVED
Allergies: PCN	Date:
	Time:
	Receiving Nurse Intials
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(O)hiective MISN T. 984 - 100	18 1/16/10 1711
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DEPARTMENT OF CORRECTIONS TRANCEED & DECEN

RECOMPONED INAIVOR	ER & RECEI	VING SCREENII	NG FORM
RECEIVED: Inmate/Health Record	RELEASED: Inmate/H		ALLERGIES:
Institution: <u>PAS</u>	Institution; MCE	-	MEETIGIES.
Date: 3/5/55 Time: 2/35 AM/PM	Date: 3/14/05 Tir		PCN
RECEIVED FROM: Institution/Work Release Center/Free-World Hospital	RELEASE FROM:	me: AM/PM	PHYSICAL EXAMINATION /
Hospital	Infirmary	Segregation	Date of last exam: 1(3i(あら
RECEIVING MEDICAL STATUS	Population	Mental Health	Chest X-Ray Date: Result: めル
Population			PPD Reading 2/3/05
Infirmary	RELEASE TO:		Classification:
	DOC Infil	rmary Mental Health	i .
Isolation	Institution (Mark D.)		Limitations:
LAB RESULTS LAST REPORT	mstitution/vvork Helease	e Center/Free-World Hospital	VSO
CBC Date Norma	al Abnormal	Wears Glasses/Contact	YES NO
Urinalysis //3//05		Dental Prosthesis	
4910		Hearing Aide	月 又 人
CUBBENT OR CHRONIC MEDICAL (DENTAL AMERICAL		Other Prosthesis	Recieving Murse
CURRENT OR CHRONIC MEDICAL/DENTAL/MENTAL	. HEALTH PROBLEMS (OR COMPLAINTS	\mathcal{U}
CURRENT MEDICATION DOSAGE AND FREQUENCY	CV		
O STAL MAD I TEQUENT	J1	1	Sent w / inmate Not sent w / inmate
		1	Sent w / inmate
			Sent w / inmate
		Released to:	
φ		Date:	Time: AM/PM
			Received X Not Received
(Received Not Received
SCHEDULE FOR CHRONIC CARE CLINIC		HEALTH RECORD 1	Received Not Received
STATE OF THE STATE		CHART REVIEWED	YES NO
DATE: LAST CLINIC:		Received by:	
			Receiving Nurse じんし Time: ユノイン AM/PM
OLLOW-UP CARE NEEDED Date T	ime With Whor	m Location (Sending Nurse	
Medical Dental		Location (Ochang Naise	Date/Appt. Made w/Whom (Rec. Nurse)
Mental Health			
Yes / No			
Figure 1 See See See See See See See See See	Open Sores	Yes No IN	NTAKE
Mental Illness Suicide Attempt		$\frac{\chi}{\chi}$	Sick Call Procedures Explained
Suicide Attempt Chronic Care	Edema Warm & Dry	X	Height 5'9"
THE REGION OF THE PROPERTY OF	Cool & Moist	XX	Weight
Mental Illness Suicide Attempt Chronic Care Special Diet Appearance OTHER PERTINENT NURSING ASSESSMENT (Noted from Impate assessment)	≥ Alert	TX 1	Blood Pressure (cv/68
Appearance	Oriented Uncooperative	X	Temperature 974
Montal Illness Sincide Attempt Chronic Care OTHER PERTINENT NURSING ASSESSMENT (Noted from Innate assessment)	Uncooperative Depressed	e X	Pulse Resp. 60/14
NUNNS	1,	(())	Other
U. Wuldney UPV	3/14/00	1/2/m -	.//
NMATE NAME (LAST EIROT MISSES)	Date	Signature of Intake Screening Nurse (F	Receiving Nurse)
NMATE NAME (LAST, FIRST, MIDDLE)	/,)	DOC#	DOB Race/Sex FAC
you was / CC	$a \sim$	197/192/	30 24 (24 1/1
S-MD-70009	J	-1 1 V 1 D 1-	



CIE 1002 (1/A)

PRISON HEALTH SERVICES, INC. SICK CALL REQUEST

1D #//30.73 Dat	Date of Request:
Mature of problem or request: I have Knots in each of my Arms.	e Knote in my about and 2
	Ricky wode Pavis Signature
DO NOT WRIT	TE BELOW THIS LINE
Date: $\frac{\cancel{J} + \cancel{J} + \cancel{J} + \cancel{J}}{\cancel{J}}$ AM \cancel{M} Allergies: \cancel{f}	RECEIVED Date: Time: APR 2 3 2005 Receiving Nurse Intials
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(O)bjective (V/S): T: P:	74 R: 18 RP: 175 WIT: 1751
re gette begger. Ho 43. Sho WIL	Signed Knots noted what ams- ted a Cheed Con Sureners. States they to tout . Keep c love.
ald w Compart of It set .	
(P)lan: MD appl gw.	
Refer to: MD/PA Mental Health Denta	al Daily Treatment Return to Clinic PRN
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	SIGNATURE AND TITLE
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PROGRESS NOTES

Date/Time	Inmate's Name: Davis Ricky D.O.B.: (130175
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4/27/05 7A	wt. 1717 120/80 85 18 7 97 5
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30111 (5/85)	Complete Both Sides Before Using Another Sheet



PROGRESS NOTES

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30111 (5/85)	Complete Both Sides Before Using Another Sheet

	Inmate's Name: DAVIS RAKY D.O.B.: 1/30/75
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PHYSICIANS' ORDERS

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AFFIDAVIT

STATE OF ALABAMA)
Barbour COUNTY)
I, <u>Beth Long</u> , hereby certify and affirm that I am a <u>Moducal Records Clerk</u> , at <u>Faster ling Corrections</u> ; that I am one of the custodians of medical records at this institution; that the attached documents are true, exact, and correct photocopies of certain medical records maintained here in the institution medical file of
one Ricky Wade Davis, AIS# 173073; and
that I am over the age of twenty-one years and am competent to testify to
the aforesaid documents and matters stated therein.
I further certify and affirm that said documents are maintained in the
usual and ordinary course of business at Acison Health Sorvice;
and that said documents (and the entries therein) were made at, or
reasonably near, the time that by, or from information transmitted by, a
person with knowledge of such acts, events, and transactions referred to
therein are said to have occurred.
This, I do hereby certify and affirm to on this the $\frac{15^{+}}{2}$ day of
<u>February</u> , 200 6 .
Beth Long
SWORN TO AND SUBSCRIBED BEFORE ME THIS THE
1 Day of <u>teluary</u> , 2006.
Day of 7 chrony, 2006. Linda A Welkinson Notary Public
Notary Public
<u> </u>

SPECIAL NEEDS COMMUNICATION FORM

Date:
To: ADOC (Ewterling) From: PHS (Ewterling)
From: PHS (Ewterling)
Inmate Name: Davis, Ricky ID#: 13073
The following action is recommended for medical reasons:
1. House in
2. Medical Isolation
3. Work restrictions
4. May have extra until 5. Other PPD Reading on (mon) 1-16-06
Comments: during 1st shif pill call
Date: 1-14-66 MD Signature: V.OV. Davbord Mclant Time: 1 p
RICHY DAVIS 173073

INSTRUCTIONS TO PATIENT	HEALTH SERVICES HICORPORATED	RGENCY
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Davis Ricky 1730731/30/75 W/m 80F	Sushepri 12/30 //	
	Davis Ricky	102002 Note (N) 800

(White - Record Copy, Yellow - Pharmacy Copy)



RELEASE OF RESPONSIBILITY

Inmate's Name: \\ \\ \text{icky} \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		
Date of Birth: 1-30 - 75	Social Security No.:	
12 0	_ Time:	A.M. P.M.
	Print Inmate's Name)	•
ustody at the		, am refusing to
accept the following treatment/recommendations:	MO Aprot /2-2	ا مد ا
I acknowledge that I have been fully informed of and undenvolved in refusing them. I hereby release and agree to hold have bersonnel, Prison Health Services, Inc. and all medical personnel action/refusal and I personally assume all responsibility for my	rmless the City/County/State, statutory from all responsibility and any ill effects v	authority all correctional
Refused to Signature of Annate).	(Signature of Medical Po	erson)
(Witness)	(Witness)	

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.

EMERGENCY

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INSTRUCTIONS TO PATIENT	
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INMATE NAME (LAST, FIRST, MIDDLE)	DOC# DOB R/S FAC.
Davis, Ricky	173073 1/30/75 W/M ECF
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EMERGENCY

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INMATE NAME (LAST, FIRST, MIDDLE)	DOC# DOB B/S	FAC.
HS.MD.70007	173073 1-3075 1/2	



RELEASE OF RESPONSIBILITY

Inmate's Name: KICKO	IAV.	and the second s
Date of Birth:/ 38	Social Security No.;	37-29-7218
Date:	0.5Time:	AM. P.M.
This is to certify that I,	et.	F *
	(Print Inmate's Name)	currently in
custody at the	•	
	(Print Facility's Name)	, am refusing to
. 1	(Specify in Detail	
I acknowledge that I have been fully inform	ned of and understand the above treatment(s)/reagree to hold harmless the City/County/State, stadical personnel from all reagrees.	commendation(s) and the risks
otion/refusal and I personally assume all respon	dical personnel from all responsibility and any ill empirical personnel from all responsibility for my welfare.	tutory authority, all correctional fects which, may result from this
Otion/refusal and I personally assume all responsible of inmate)	dical personnel from all responsibility and any ill ensibility for my welfare. (8) on store of Methods and any ill ensibility for my welfare.	fects which, may result from this
otion/refusal and I personality assume all respon	ensibility for my welfare.	fects which, may result from this

**A refusal by the inmate to sign requires the signature of at least one witness in addition to that of the medical staff member.



EMERGENCY

ADMISSION DATE , TIME ORIGINATING FACILITY	F161	<u> </u>			
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MUNS, KICH	[//]	30130	1301/5	WIT	ray



DEPARTMENT OF CORRECTIONS

KITCHEN CLEARANCE PHYSICAL ASSESMENT

			YES I	NO	
	ANY OPEN SORES OR RASHE HANDS, ARMS, FACE & NECK		<u> </u>	<u> </u>	
	TB TEST CURRENT	-	<u>X</u> _		
	DOES PT. SHOW ANY OBVIOUS SIGNS OF ANY OTHER DISEAS		_ ×	_	
OTHER:					
PROPER HAN EVALUATION	AS BEEN INFORMED OF THE I DWASHING, NOT TO HANDLE WHEN NECESSARY AND TO N OF ANY UNITSS.	FOOD WHI	LE SICK.	SEEK MED	ICAL S SHIFT
MEDICAL AUTHOF	ve statement, is, true, to the best of n	DATE: _		5/25	
PATIENT SIGNATU	JRE: X/A/C/S/JAVIS	DATE:_		V 05	
EXPIRATION DATE	::_ (rdefinile				
INMATE NAME (LAST, FIRS	ST, MIDDLE)	DOC#	DOB	Race/Sex	FAC
Davis	Kicky	TH3073	1/36/75	ω/m	EAS
	•				

PROCEDURE FOR ACCESS TO HEALTH CARE

Treatment for routine medical complaints and mental health-complaints are processed through nurse screening seven days a week. Inmates must complete a sick-call screening form and turn this form into medical services for processing. You may obtain screening forms from any dorm cube or shift commander's office. you need to place the screening form in the locked box located at the dining hall. All health service requests are subject (a \$3.00 c) pay being deducted form your PMOD account, depending on the nature of your request. Forms for segregation inmates will be collected by nursing personnel at 4:00am medication rounds. Doctor's clinic is held Monday through Friday excluding holidays or an unexpected emergency.

Inmates on sick-call screening must report for screening or sign a refusal of treatment form declining care. Screening for population is held on 1st shift at approximately 7:00am. Screening for segregation is held during the morning pill call rounds. Sick-call screening is held Sunday through Friday.

Fill call times for this institution are as follows:

POPULATION
4:00 am
9:00 am
9:00 am
5:00 pm

DIABETIC
SEGREGATION
4:00 am
10:00 am
5:00 pm
5:00 pm

Medical request on weekends and holidays are reviewed. Any request for medical attention that cannot wait until the next sick-call clinic will be processed at that time. All other request will be held until regular Sunday through Friday sick call. Medical emergencies, such as those involving intense pain, potential life-threatening situations, or when delaying treatment might cause permanent damage are dealt with at any time. Advise the nearest Correctional Officer of an emergency, so prompt access to health care is provided.

You are required to sign up for Dental sick call using the same procedure as medical sick call. Population and Segregation Dental Screenings are held weekly on Monday evenings at 1:00pm in the Health Care Unit. Follow-up care, if needed, is scheduled at this time. Emergency dental service is provided 24 hours a day with a dentist on call. Those not meeting scheduled appointments must sign a refusal of treatment form.

Your-medical care is important. This is a joint effort between you and the Health Care Staff. Prescribed medications are to be picked up at pill-call, appointments kept, and education in services attended.

Comfort medications, such as cold medicine, headache medicines etc. are available in the canteen.

We ask that medical complaints against the Health Care Unit try and be resolved face to face. If concerns cannot be resolved verbally, a written complaint may be filed. You may get this form in the Health Care Unit. You must complete this form listing specifically the reason for dissatisfaction, steps you have taken and the action requested to resolve the problem. Return this form to the Health Care Unit.

Inwate Signature AIS# Weight H

3/15/05 Date

2140

FROM:

Sheriff Mac Holcomb

	Marshall County
TO:	Department of Corrections Transfer Agent Supervisor FAX# (334) 240-3380 AND Medical Director (CMS) Kilby C.F. FAX# (334) 215-6681
Sub	ject: Authorization for Required Immediate Medical Care for State Inmate.
4	Inmate: Riky Wase Davis SS/AIS:
1. <u>.</u> -	Condition requiring immediate medical treatment outside jail: No medication ordered at this time Scheduled to have nodules removed (benign)
2.	Medical Professional who determined immediate care required: Phone
3.	Date/Time DOC contacted
4.	Has determination been made that offender has been convicted and transcript forwarded to DOC? YesNo
	nitted by:
A	Phone (256) 582-2034 Ext. 30

RECEIVING SCREENING FORM

INMATE'S NAME: DAVIS RICKY DATE: 118 105 TIME	E: 10:45 AM
DOB: 1/30/75 OFFICER: Darnel Marce INSTITUTION:	KILBY
RECEIVING OFFICER'S VISUAL OPINION	
	YES NO
Is the inmate conscious?	X —
Does the inmate have any obvious pain or bleeding or other symptoms suggesting the need for doctor's care?	
Are there any visible signs of trauma or illness requiring immediate emergency or doctor's care?	_ \(\)
Any obvious fever, jaundice, or other evidence of infection which might spread through the institution?	_
Is the skin in poor condition or show signs of vermin or rashes?	- /
Does the inmate appear to be under the influence of alcohol, or drugs?	_ (
Are there any signs of alcohol or drug withdrawal? (Extreme perspiration, shakes, nausea, pinpoint pupils, etc.)	
Is the inmate making any verbal threats to staff or other inmates?	- 7
Is the inmate carrying any medication or report that he is on any medication which must be continuously administered or available?	$\overline{}$
Does the inmate have any obvious physical handicaps?	
FOR THE OFFICER	-
Was the new inmate oriented on sick/dental call procedures?	
This inmate was a. Released for normal processing	
b. Referred to health care unit	
c. Immediately sent to the health care unit.	

This form will be completed at receiving and will be filed in the inmate's medical jacket to comply with NCCH Standards.

ALABAMA DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES MENTAL HEALTH 30/90 DAY SEGREGATION REVIEW

Inmate Name: Davis Ricky	O DAY SEGREGATION REVIEW
	IS#:73073 Institution: ECF
Date Review Completed: 1-6-06	Onto Planting Institution:
30 DAY REVIEW	Date Placed in Segregation: 8-30-05
ALDOC Psychologist/Park	LOODAY REVIEW RIAM MY AM
MENTAL STATUS EXAMINATION Affect:	onducting Review: Brian With the Will
Affect:	DO DAY REVIEW Bush Mitchell Onducting Review: Brian Mitchell, Psychological Asst. II
Appropriate for Segregation	Appearance:
Concentration:	Appropriate for Segregation
	Intellectual Functioning:
Appropriate for Segregation	List +1 .
	Within Normal Limits Memory:
Appropriate for Segregation Orientation:	
The state of the s	Intact Speech:
Appropriate for Segregation	
Other:	Appropriate for Segregation
PEUALICA	
BEHAVIORAL OBSERVATIONS Aggressive	
Agitated Irrational	· · · · · · · · · · · · · · · · · · ·
Delusional Labile	Passive
Eye Contact Lethargic	Rational
Hallucinating Loose Assoc	ciations Terrified/Crying
Hyperactivity Manipulative Paranoia	Withdrawn Suicidal
COMMENTS:	Other:
•	
RECOMMENDATIONS:	
X SEGREGATION BLAGGIATION	Wow
SEGREGATION PLACEMENT	NOT IMPACTING INMATE'S MENTAL HEALTH
REFERRED FOR PSYCHIATRIC Other:	NOT IMPACTING INMATE'S MENTAL HEALTH IMPACTING INMATE'S MENTAL HEALTH IC EVALUATION
_	
Inmate Name	
	AIS#

ALDOC Form 465-01

ALABAMA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES

MENTAL REALTH 30/90	DAY SEGREGATION REVIEW			
\sim \sim \sim \sim \sim	IS#: 173073 Institution: Easterling			
	Date Placed in Segregation: 8-30-05			
30 DAY REVIEW				
	90 DAY REVIEW Bush Nitchell			
MENTAL STATUS EXAMINATION	onducting Review: Brian Mitchell, Psychological As	st. II		
Affect:	Appearance:			
Appropriate for Segregation	Appropriate for Segregation			
Concentration:	Intellectual Functioning:			
Appropriate for Segregation	Within Normal Limits			
Mood:	Memory:			
Appropriate for Segregation	Intact			
Orientation:	Speech:			
Appropriate for Segregation Other:	Appropriate for Segregation	•		
Other:				
BEHAVIORAL OBSERVATIONS				
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Agitated Labile	Passive Rational			
Delusional Lethargic Eye Contact Loose Ass	Terrified/Crying			
Hallwainer	sociations Withdrawn			
Hyperactivity Manipulat	tive Suicidal Other:			
COMMENTS:	Outer			
Community.				
•		-4		
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PECOMMENDATIONS				
RECOMMENDATIONS: X SEGREGATION PLACEMENT	NT NOT U.O. TO			
BEGREGATION FLACEMEN	NT NOT IMPACTING INMATE'S MENTAL HEALTH NT IMPACTING INMATE'S MENTAL HEALTH			
REFERRED FOR PSYCHIATRIC EVALUATION Other:				
	•			
Inmate Name		-		
	AIS#			
		ll .		

ALDOC Form 465-01

ALABAMA DEPARTMENT OF CORRECTIONS INMATE ORIENTATION TO MENTAL HEALTH SERVICES

The Alabama Department of Corrections provides the following mental health services:

- Assessment and treatment of mental illness
- Referral to a psychiatrist, if necessary for medication
- On-going psychiatric treatment
- Group and individual counseling
- Assistance in dealing with stressful problems (adjustment to prisons, grief and loss, family problems)
- Crisis intervention
- Residential mental health treatment and hospitalization, if necessary

If you wish to speak with mental health staff about routine matters such as scheduling for group or individual counseling, send in a Health Services Request form.

In emergency situations or if you have concerns that need to be addressed immediately, contact any correctional officer so that you may receive mental health assistance as soon as possible.

Your participation in mental health services is voluntary except in emergency situations or when you have been provided due process through administrative review.

If you believe the mental health services provided to you are inadequate, you may file an inmate grievance.

Information about the mental health services provided to you is confidential except in the situations when mental health staff believe that you may be:

- Suicidal
- Homicidal
- Presenting a clear danger of injury to self or others
- Presenting a reasonable clear risk of escape or creation of institutional disorder
- Receiving Psychotropic medication
- Requiring movement to a special unit or cell for observation and treatment
- Requiring transfer to a psychiatric hospital outside of the prison
- Requiring a new program assignment for mental health reasons

Mental health staff has a legal duty to report to appropriate authorities any unreported suspected abuse or neglect of a child.

Mental health and medical staff will have access your mental health records when completing their duties. The following persons may have access to your mental health records on a need to know basis:

- Warden of the institution or designee
- Internal investigation staff and legal counsel working with the ADOC
- Departmental and accrediting audit staff
- Persons authorized by a court order or judgment

All other persons or agencies require an authorization for release of information signed by you before gaining access to your mental health records.

This information on this form has been explained to me and I have received a copy of the information for my future reference.

73073B 1-28-05 Date Signed

avis, Ricky

PSYCHOLOGICAL UPDATE

Name: Guran	AIS#: 17 275 (>
Date://	Date of Birth:/ 3 / 75	Age:
Inmate	was last evaluated by ADOC p	sychology staff member
A diagnosis of	was m	ade and the inmate was
recommended for participat		ado and the initiate was
	1 DAG	
	l recommendations are made as a result	of the current interview.
I. Educational Needsb. Spe	ecial Educationc. Trade School	d. Junior College
II. Mental Health Needs		
A. Refer to psychiatrist	E. Sexual adjustment	_ I. Self-concept enhancemen
B. Substance abuse counseling	gF. Reality therapy	J. Healthy use of leisure
C. Depression	G. Anger-induced acting out	_ K. Personal development
D. Stress management	H. Values clarification	/
Date referred to psychiatrist		
III. RECOMMENDAȚIONS/REI	MARKS: V V // V	
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1/15/610	Communal	
	- One a controller in	interior \
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MENTAL HEALTH CODE:	SMI HARM HIST	NONE
Evaluation Completed by:	Date Date Date Date Date Date Date Date	e:

N-259 A (2/2001) White to Central Records Yellow to Institutional File Pink to Data Entry and forwarding to Medical Record

ALABAMA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES

Referred by: PSYCHIATRIC EVALUATION
Admission to Institution
Keason for Referent (no.
NEW ADM. TO KILBY C.F. INCAR, - 5-6-MOS.
CH - REC. STEL. Prop.
S - /-/
Psychiatric History (Inpatient/outpatient/dates of treatment/medications prescribed):
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14 4.0, Rx- Bus Pur Fon ADHD, x + Fun, @ M. H.c.
No oine ty
DEVIES CONNENT SP
Pertinent Medical History (allergies):
12x - x
ALLERGIES-PON
HEAD THE
SELECTION TO X
HEAD INJ - X SEIZURES - X Substance Abuse History:
Sold All All All All All All All All All A
5TOUT-18, POT-21, MATURAMPH 29
1
TX- The Aco, Rostris elpx 28 dors. com x 741.
Pertinent Personal/Family Windows
Pertinent Personal/Family History (inmate's sentence):
LIVING - E GINL FRIEND, SINGLE.
School- Fhrs. Work- HAG, CONSTRUCTION Institutional Adjustment (current placement): PRIPR- 96-ct- Roc. Srow. Prep- 5= 2 has /28-9 ms 91- Nov. Serv. Prep- 5- 34KS/79n.
Institutional Adjustment (current places of WORK - It Afe , CONSTRUCTION)
PRIPR - 181 - 014 - Pro-
18 - Ch 1-80. Or 60. 1-101- 5- 27h5/28-9 may
71-162, STE. Ruel 5-3445/79n.
JV- 15- TOSPI- DONI. X T NU.
Inmale Name Page 1 of 2
Inmale Name DANIS, PICKY AIS# 173073
DAUIS, 12-1214 AIS# 173073

ALABAMA DEPARTMENT OF CORRECTIONS MENTAL HEALTH SERVICES

PSYCHIATRIC EVALUATION
Mental Status Examination:
Manual, or and or the property of
Mood and Affect: STABLE IN MOOD
Speech and Language: WムL
Thought Process:
W りし Thought Content and Perceptions:
WNL
Cognitive Assessment/Memory:
insignt/Judgement:
Sleep/Appetite:
Suicide/Violence Risk Assessment:
Past Suicidal Ideation/Attempts (dates and methods):
Current Suicidal Ideation and Behavior:
Poot 3 Note with a position of the control of the c
Past Violent/Assaultive Behavior:
Current Violent/Assaultive Ideas/Behavior:
Diagnostic I
Diagnostic Impression Axis I: ちいまいましたり、
Axis II: DEFIN KOD
Axis III:
Axis IV:
Axis V: 25
Treatment Recommendations (including medications/labs ordered/special housing)
Mo Mill. Sendles School &D.
Mental Health Code: SMI HARM HIST NONE
Psychiatric Follow-Up Required Within: Days
Psychiatrist Signature Date 2/1/85
Page 2 of 2
Inmate Name DNIS, PICKY AIS#173073

Dr. Paul Beecham **MHM Correctional Services**

MIN

	VINC.
ALABAMA DEPARTMENT OF COL MENTAL HEALTH SERVICE	Mental Health P&P # 55
COMMA DEPARTMENT	
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Problems	
Because With other inmates	
Problems with other inmates: Recent stress:	
Recent stress: Other:	
EVALUATION OF MENTAL STATUS Homisides	
Suicidal STATE	
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	(1 p)
U Hostilo	☐ Physical complaints☐ Sleep district.
☐ Hostile, angry ☐ Withdrawn	☐ Sleep disturbance
Other inappropriate behavior: Withdrawn Poor hygiene	
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HISTORY OF PSYCHOTROPIC MEDICATION PRIOR TO OTHER: COMMENTS: And Legath Legath Referred by: Referral for psychiatrist (rofe MENTAL HEALTH AND	TEOLITION/TRANSFED
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Robert Williams	Ann
Referred by: Handa	auren 1
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Referral for psychiatrist (referral has been screened by mental he MENTAL HEALTH FOLLOW-UP: EVALUATION/TREATMENT/DISP	· ·
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Milt. EVM	_ / /
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Inmate Name	
	/ /
Date:	2/1/00
AIS#	1.100
The stay	
	50000 H
Dr. Paul Beecham	\(\) \(\)

Dr. Paul Beecham MHM Correctional Services

Case 2:06-cv-00010-MEF-TFM Document 21-2 Filed 03/06/2006 Page 86 of 100 IN RDISCIPLINARY PROGRESS N(:S

DATE	TIME	NOTES	SIGNATURE
· · · · · · · · · · · · · · · · · · ·		(

			~

Patient's Name, (Last, First, Middle)	AIS#	Age	R/S	Facility
Davis, Ricky	173073	30	w/m	rulbe
F-61				

A BAMA DEPARTMENT OF CORRECTA S MENTAL HEALTH SERVICES

RECEPTION MENTAL HEALTH SCREENING
Institution: Date/Time Inmate Received: 1-88-65
Date/Time of Screening: / Signature/Title of Screener: L. Hondorson LPN
Signature of Science: Company CPN
MENTAL HEALTH TREATMENT PRIOR TO ENTERING THE ALDOC:
C 1 a argo rsychotropic medication.
11 Yes 2 No Medication turned over to ALDOC upon arrival?
Yes UNo Mental health follow-up in last 90 days:
U Yes 11 No Suicide/self-harm attempts in last 90 days:
Surpanient desintern:
/
Name of the state
2)
The state of the s
Ves No Special education classes: gth gade lcl
INMATE SELF-REPORT OF CURRENT STATUS:
U Yes & No First incarceration (reaction):
The second depression of the second s
U Yes U No Thinking about suicide: U Yes U No Has plan for suicide:
Free set autority.
Yes No Reports hallucinations:
- Post and a second sec
BEHAVIORAL OBSERVATIONS:
☐ Poor eye contact ☐ Poor hygiene ☐ Unable to pay attention ☐ Unresponsive
Disoriented Overly anxious II linguistic Disoriented
U Crying
Appears to be hearing voices or seeing things
☐ Hostile ☐ Other unusual behavior:
DISPOSITION/ PLACEMENT RECOMMENDATION (based on reception mental health screening): Routine housing and mental health follow-up Emergency mental health referrel
Carteau psychotropic meds verified/interim supply ordered
Inmate Name
Maria Ricky AIS# 1/30/30
ALDOC Form 450-01

4 of 6



YEARLY HEALTH EVALUATION

I.	HISTORY – (LPN or RN)	YES NO	COMMENT(S)
	Weight Change (greater 15 lbs.) (Compare Weight Below) Persistent Cough Chest Pain Blood in Urine or Stool Difficult Urination Other Illnesses (Details) Sinoke, Dip or Chew ALLERGIES		Last weight at least 6 months ago Past hx 1/2 play
Weig	ht 180 Temp 98 Pulse 98 Exam 20 20 20 20 20 0U	If greater th	d Pressure 10 8 BS-17 an > 140/90, repeat in Thour.
II.	TESTING - (LPN or RN)	Refer to M.I	D. if remains > 140/90.
	Tuberculin Skin Test (q yr) Past Positive TB Skin Test →	Date given 1-14-0 Read on 1-16-24 Survey Completed	Results 6 mm
*	(Chest x-ray if clinical symptoms)	Date	Results
***	RPR (q 3 yrs) EAG (baseline at 35, over 45 q 3 yrs) Cholesterol (at 35 then q 5 yrs) Tetanus/Diptheria (q 10 yrs) (if done today) Optometry Exam (@ 50 if not already seen) Mammogram (females @ 40, q 2 yrs/other M.D. order)	Last Given 2064 Site given Date R	Results NP Due 2014 Dose Lot # esults
Ш.	PHYSICAL RESULTS — (RN, Mid-Level,	M.D.)	
33 33 26	Heart Lungs Least Exam Rectal (yearly after 45) with Hemoccult Pelvic and PAP (q 1 yr)	Self EYam explo Results DIA Results NIA	ally airod. Wood undasting lesults_
Facility	Easterly Nurse Signature Smck	Linnon V	Date 1-14-06
M.D. or	id-Level Signature	· · · · · · · · · · · · · · · · · · ·	Date 11706
INMATE	I AME AIS#	D.O.B.	RACE/SEX
Davis	. Ricky 173073	1-30-75	WIM

104	$\gamma \gamma \gamma \gamma$	561	ELOGY	Davis, Ricky
FACILITY	KYCE\ZEX	D.O.B.	#SIV	INWATE NAME (LAST, FIRST, MIDDLE)

- Sate		Witness
50/84/18	ME	Many July Bong
SS# Date #SS	#SIV/	Inmate Signature
50/80C/10 818L-6t-189	EL0EL1	SUR Child
Zip Code	State	City
Ehb-TLS (1957) 8900-985(95	() (H	9H1H
Phone Number		Street Address
35016 Zin Code		901 XOG, Ox,
qiden	Selatio A	Name
- UAG	W	COUNTY GOODS
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In the event of a serious injury or illness, I request the following person be notified:

NOTIFICATION OF NEXT OF KIN

DEPARTMENT OF CORRECTIONS

PRISON HEALTH SERVICES, INC.



INTAKE HEALTH EVALUATION

NAME: <u>Davis</u>, <u>Ricky</u> AIS#: <u>173073</u> D.O.B.: 1-30-75

Age 30 Sex	M		Race W H	eight	5	'9" Weight /@	00	
Temp: <u>98.1</u>	B/P: <u>/</u>	10/	60 Pulse:	64		Resp: /6		
** B/P – If greater	than 1	40/9	0, repeat in 1 hour. Re	fer to	Mid	-Level if B/P remains u	ıp.	
Do you now or	have yo	u <u>eve</u>	r had, or been treated for:	7.	SBS	:-77		
Problem	Y	N	Problem	Y	N	Problem	Y	N
Head Trauma			Gastritis		V	HIV/AIDS ***	Ť	V
Loss of Consciousness		V	Ulcers		/	***Medications Verified		T
Severe Headaches		V	Bleeding			Hepatitis - Type		1
Vertigo/Dizziness		V	Gall Bladder/Pancreas		V	Gonorrhea	T	1
Vision Problems		~	Liver Problems		1	Syphilis		
Hearing Problems		~	Arthritis		1	Lice, Crabs, Scabies		
Seizures		V	Joint Muscle Problem		/		1	1
Strokes		/	Back/Neck Problem		~	LMP		
Nervous Disorders		/	Kidney Stones/Dz		/	Date		
DT's		V	Bladder/Kidney Infection		/	Duration		
Heart Condition		1	Alcoholism			Normal		
Angina/Heart Attack		1	Drug Abuse	~		Regularity		
High Blood Pressure		/	Psychiatric History		/	Gravida/Para		
Anemia/Blood Disorder		~	Suicidal Thoughts**		/	AB/Mscarriage		
Sickle Cell or Trait		_	**Immediate M.H. Referral			Contraception		
Lung Condition		V	T.B.			Type:		
Asthma *			PPD - date given: 1/3	1/05				
*Peak Flow Reading	-	_	RFA) FA			Lab Tests - Dates	N	Ab
Bronchitis		<u>/</u>	Date read: 2 - 3 - 05			Diagnostic Profile II		
Emphysema		<u> </u>	Results: Omm			RPR		
Pneumonia		/	Visual Acuity			Urine Dip Stick		
Diabetes		<u>/</u>	OD OS					
Hay Fever/Allergies		/	OU 20/20			EKG (@ age 35)		
Immunization History:	,	2004	t - Stated Cer	nen	+	Statod		
***HIV Medications:	_							
Acute or Chronic Problem	Noted:	: 3	Y N Refer to M	Iid-L€	evel o	r M.D. if yes.	3.0	
RN or Mid-Level, Sign	nature			- Da	ate/T	<u>_1 31lo5 @ 11:2</u> 'ime	<u>ں</u>	

I have read the access to health care information sheets and have been given a copy. I understand how to access health care.

AIS#

Date_1/3//05

Date/Time

K/S W/W

M.D. or Mid-Level Signature

Medications Ordered:

		ectal/Guiac (required @ 45 and up) eferred/follow-up:
		elvic Pap
		enitals Injuries/Lesions
MARIN	1/	xtremities Edema, Pulse
full from	, /	sck ROM, Spasm, Injury
านุก	7 /	Flank Tenderness Bladder Tenderness/Distention
4×58 F)	3/	hbdomen Bowel Sounds Palp, G/R/T, Hernia
ters		Heart Ausc Rate, Rhythm Mumurs, Ectopy v
bungs the belock		Chest Config. Ausc/Resp Cough/Sputum BreastMasses
Supple, full		Neck C-Spine, Mobility Veins, Carotids Thyroid, Lymph Nodes
74M	7	Throat Teeth, Gums, Dentures Mouth, Tongue, Tonsils Airway
74(1)		Nose Epistaxis Sinuses
TUM	1	Ears Appearance Canals, TMs, Hearing
GERRUN	1	Eyes Glasses/Vision Pupils Sclera, Conjunctiva
אתר		Неаd Normocaphalic Atraumatic Hair, Scalp
\$ - 50005 2001		Jaundice Diaphoretic Rash, Lesions, Infestations Needle Marks Color, Turgor
10 Hoos- multiple		Skin Injury, Bruises, Trauma
Exomu	^	Meuro Mental Status Intox Withdrawal, Tremor Meuro-Deficits
ambulates 3 dyl	1	General Movement Deformity Pain, Bleeding Habitus, Hygiene
tnemmo2\ndA	N	JASIAЯЧЧА

D.O.B.: :#SIV NYME:

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HEALTH CLASSIFICATIONS:

No Restrictions

(Circle One)



INTAKE SCREENING Date Last Name: First: Middle: Birthplace: Tenr DOB: FEMALES: Pregnancy test Pulse It level > 200, repeat within 48 hours. Above 300 call M.D. (circle one) Positive Negative Previous Hospitalizations/Surgeries/Major Illness/Current Illness: What? Where? Previous Incarcerations (Date & Facility) Medications: None Special Diet (Prescribed) Allergies: Past Positive TB Skin Test (circle one) YES - (Complete TB Screening Form) ANY INMATE WHO IS UNCONSCIOUS, SEMICONSCIOUS, ACTIVELY BLEEDING, IN ACUTE PAIN AND URGENTLY IN NEED OF MEDICAL ATTENTION SHOULD IMMEDIATELY BE REFERRED FOR EMERGENCY CARE **CLINICAL OBSERVATIONS** 1) Level of Consciousness: () Alert (YOriented; time, place, person 3) Substance Abuse: () Suspected () Lethargic () Stuporous () Comatose () Use () Withdrawal Symptoms () Drugs (WAlcohol Case ii () Current intoxication/Abuse Describe: Describe- What kind? Amount/Frequency? Mari Juan 2) General Appearance ()Normal() Abnormal • If confirmed Benzo use, then call M D. If can not be confirmed, call M D 3) Signs of Trauma () Yes Last Use: (Time(Date): 4a) Behavior/Conduct: (Calm ++ Cooperative () Non-Violent 4b) Affect/Mood: () Normal () Manic () Agitated () Uncooperative () Violent () Euphoria () Flat () Emotionally Confused () Manipulative () Disorganized Describe: Describe: 4c) Perceptions: () Delusional () Hallucinations () Hearing Voices 5a) Is there h/o actual suicide attempt? () Yes + No 5b) Does pt describe current suicidal thoughts or ideations? () Yes 5c) Is there evidence 5d) High risk pt may become assaultive towards staff? () Yes If ANY of the above in #5 are circled, staff MUST describe here, include previous Triggers for Suicide Watch Triggers for Close Watch - Currently Suicidal - Emotionally distraught and unable history and dates: - History of actual attempt to regain composure by end of - Fails to maintain control on *Any abnormal observations #4 or 5 require immediate Mental Health intake process Close Watch Y or N - Actively hallucinating or not Referral. making any sense Y or N ()No 6a) Communication Difficulties () Yes 6b) Memory Defects () Yes ()No 6c) Hearing Impairment () Yes 6d) Speech Difficulties () No () Yes 7) Physical Aids: () None () Glasses () Contacts () Hearing Aid () Dentures () Cane () Crutches () Wheelchair () Walker () Braces () Artificial Limb () Other 8) Additional comments, complaints, symptoms: None S) Swollen Glands 0) Signs of Infection Skin Intact A) P) If known Diabetic * Call M.D. for order . Initial Insulin given: I have answered all questions truthfully. I have been told and shown how to obtain medical services. I hereby give my consent for

health services to be provided to me by and through PRISON HEALTH SERVICES

ALABAMA DEPARTMENT OF CORRECTIONS

PROBLEM LIST

INMATENAME Davis Ricky
Medication Allergies: PCN (hh)
Medical: Chronic (Long-Term) Problems Roman Numerals for Medical/Surgical
Mental Health Code: SMI HARM HIST NONE Capital Letter for Psychiatric Behavior

Date Identified	Chronic Medical Problem	Mental Health	Date	Provide
2-3-0		Code	Resolved	Initials
9/1-	5 PPD- pmm Fillialities Canadas			
// 1/0) 	11/22/05 Hep. B Vacc. #1 # 12/23/0			1
	1 4// 4 11 12 12 12 12 12 12 12 12 12 12 12 12	6 Hep. B Vacc. #2 (BVB004BA (20/2006		7

**If Asthmatic label: Mild – Moderate – or Severe.

Hepatitis B vaccine 03/06/2006 Sent 100 Form

FACILITY NAME_	Easterling	Correctional	Facility
-	J		1

RICKY DAVIS	W/173073
Inmate Name	AIS Number
Inmate Signature	Date
Dose Given 20 wcg.	1 ml) / 2 nd dose
Site Given B deltoid	
Administered by	MPaegne RN

Lot Number and Expiration Date AHBYBOOHBA

Hepatitis B Vaccine Consent Form

FACILITY NAME East	esling
RICKY DAVIS Inmate Name	173073 Dob AIS Number 1/30/75
RICKY PAVIS Inmate Signature	<u> </u>
Dose Given 1 ml.	
Site Given Ddeltoid	
Administered by	Payre Por
Lot Number and Expiration I	Date_ Lot# AHBVB004BA EXP. 01/20/2006

11/21/2005





DEPARTMENT OF CORRECTIONS

DENTAL RECORD TREATMENT

Date	10010 #	Tooth # Diagnosis Treatment					
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PATIENT CONSENT AND AUTHORIZATION FOR DENTAL TREATMENT

Patient Name: DAVIS Ricky BCDC#: 173073

- 1. I agree to having dental X-Rays taken of my teeth and jaws in order to determine my dental problems.
- 2. I have had a treatment plan explained to me, including alternatives or the recommendation of no treatment.
- 3. I consent to the use of local anesthetics or other medications and that there may be side effects, including allergic reactions and this has been explained to me.
- 4. I have had the opportunity to ask questions which have been answered to my satisfaction.
- 5. I understand there is no guarantee of success or permanence of the treatment.

Patient's Signature

Date

Dentist's Signature

Date



DEPARTMENT OF CORRECTIONS

MENTAL HEALTH SERVICES

DENTAL RECORD

DENTAL EXAMINATION	DENTAL EXAMINATION RESTORATIONS AND TREATMENTS				
SESSOCIONES DE LA COMPANSION DE LA COMPA	RESTORATIONS AND TREATMENTS				
E 2 3 4 5 6 7 8 9 10 11 12 3 3 3 30 29 28 27 26 25 24 23 22 21 21 21 21 21 21 21 21 21 21 21 21	13 14 15 816 FF	E 1 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	28 27 28 25	9 10 11 12 13 24 23 22 21 20	14 15 16 F
Date of Initial Examination		nitial Classification			
Oral Pathology Occlusion	Gingivitis Vincent's Infectio Stomatitis Other Findings	on			
Roentgenograms Health Questionnaire	Periapical Bitewing Other				
YES NO Rheumatic Fever Allergy (Novocaine penicillin, e Present Medication Epilepsy Asthma Diabetes HIV			V.D. Hepatitis Anemia or Bleeding Heart Disease High Blood Pressul Kidney Disease Other Disease		
Date Tooth # DX	SERVICES RE	ENDERED			
	1 1 2 7	LINAS NOTE WATER GIVES	n had A gww; No	Initials	Class
INMATE NAME (LAST, FIRST, MIDDLE) DAVIS, Ricky		DOC#	DOB 1/30/75	R/S	FAC.
PHS-MD-70015			/ - /	<u>-</u>	<u></u>

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DEPARTMENT OF	CORR	FCHONS /	$(\!/\!)$	State ID		173023
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Requesting Physician/PA/NP		Date of mouest	Time of request	Routine	Priority	Transportation or special needs
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HISTORY/DIAGNOSIS:			1 /2 -ft -2m)	•		
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